SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

Filing at a Glance

Company: LifeSecure Insurance Company

Product Name: Multi-Life Application Filing	SERFF Tr Num: LFSC-126136721	State: ArkansasLH
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed	State Tr Num: 42479
Sub-TOI: LTC03I.001 Qualified	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Harris Shearer
	Authors: Sue Howard, Judy Lucas	Disposition Date: 06/12/2009
	Date Submitted: 05/26/2009	Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/12/2009	Explanation for Other Group Market Type:
	State Status Changed: 06/12/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Re: LifeSecure Insurance Company, NAIC #77720

Multi-Life Applications – Form LS-0204A ST 08/09

Form LS-0204 ST 08/09

Form LS-0205 ST 08/09

Form LS-0051 ST 08/09

SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

Enclosed for your review and approval is our new Multi-Life Applications. These applications will be used with our Long Term Care Insurance Policy (Form # LS-0002 ST 07/07) previously approved for use in your state on 09/10/2007. These applications are new and will not replace any forms currently approved in your state

These applications are designed to be used as either a simplified issue application (completing limited sections of the application) or if they do not qualify based on the criteria (amount of Benefit Bank chosen, age of the proposed insured and if they are applying during the enrollment period and meet the definition of actively at work), then completing the full application. All coverage is individually underwritten and all applicants will be issued a the policy at Multi-Life rate class as detailed in the Actuarial Addendum

There are 3 applications for your review..

Form LS-0204A ST 08/09 is the paper application. This application will be used by licensed agents appointed by our company either in person or via the phone. If the agent is taking the application over the phone, the agent will mail the completed application to the insured with all of the required forms and disclosures for review and signature.

Form LS-0204 ST 08/09 is an agent sold electronic application. This application will be used by agents to take an application online and submit electronically using a voice authorization. This is the same process used in our agent sold online application previously approved by your department.

The PDF output of this electronic application is also submitted. This document has the same form number and is being sent to reflect the actual printed version of the online application that will be generated and included with the approved policy documents.

Form LS-0205 ST 08/09 is a self-serve electronic application. This application will be used by applicants to enter their information and submit electronically using an “I accept” button electronic signature.. This application will be done after a presentation to the employer group or an association by one of our licensed agents.

The agent will be available to assist with this process or for questions. All required disclosures and documents will be available to the proposed insured either electronically (linked through the application or via paper by the agent if the insured prefers.). The PDF of this version is also enclosed as the end result document that will be issued and sent to the insured with their approved policy.

SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

We are also submitting our revised Schedule of Benefits. This document has been revised to reflect the new rate class of Multi-life. We have revised the form number to reflect this change.

We trust these forms will be acceptable for approval. Please feel free to contact me if you have any questions or need additional information. Thank you in advance for your attention.

Sincerely,

Sue R. Howard
Compliance Manager

Company and Contact

Filing Contact Information

Sue Howard, Compliance Manager
10370 Citation Drive
Brighton, MI 48116

Showard@lifesecureltc.com
(810) 220-8774 [Phone]
(810) 220-7707[FAX]

Filing Company Information

LifeSecure Insurance Company
10559 Citation Drive
Suite 300
Brighton, MI 48116
(810) 220-8774 ext. [Phone]

CoCode: 77720
Group Code: 572

Group Name: BCBS of MI GRP
FEIN Number: 75-0956156

State of Domicile: Michigan
Company Type: Life, A & H

State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$170.00
Retaliatory?	No
Fee Explanation:	6 forms at $20.00 = $120.00 1 Set of Rates= $50.00

SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

Per Company: No

SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
LifeSecure Insurance Company	$170.00	05/26/2009	28087248

SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Harris Shearer	06/12/2009	06/12/2009

SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 06/12/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Explanation of Variability		Yes
Form	MultiLife Application-Agent Sold Paper		Yes
Form	MultiLife Application-Online-Agent Sold		Yes
Form	MultiLife Application-Self Serve		Yes
Form	Schedule of Benefits		Yes

SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: LS-0204A ST 08/09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LS-0204A ST 08/09	Application/ Enrollment	MultiLife Application- Agent Sold Paper Form	Initial			LS-0204A ST 08.09 - Agent Sold Paper- John Doe.pdf
	LS-0204 ST 08/09	Application/ Enrollment	MultiLife Application- Online-Agent Sold Form	Initial			LS-0204 ST 08.09-Online Screen Shots- Agent Sold- John Doe.pdf LS-0204 ST 08.09 - Online Agent Sold PDF John Doe.pdf
	LS-0205 ST 08/09	Application/ Enrollment	MultiLife Application- Self Serve Form	Initial			LS-0205 ST 08.09- Online Self Serve Screen Shots John Doe.pdf LS-0205 ST 08.09- Online Self Serve PDF Output- John Doe.pdf
	LS-0051 ST 08/09	Application/ Enrollment	Schedule of Benefits Form	Revised	Replaced Form #: LS-0051 ST 08/09 Previous Filing #: LS-0051 ST 05/07		LS-0051 ST 08.09_Schedule of Benefits.pdf

LifeSecure Insurance Company

Multi-Life Application

Sections F, G and H are *not* required for those applicants who qualify for Simplified Issue.

LifeSecure Insurance Company
10559 Citation Dr., Ste. 300
Brighton, MI 48116

Section A: Personal Health History

1. Within the *past 12 months*, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of Long Term Care Facility? Or, within the *past 12 months*, have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? ☐ Yes ☑ No

2. Do you *currently* use any of the following: ☐ Yes ☑ No
   - Walker
   - Wheelchair
   - Quad Cane
   - Motorized scooter
   - Hospital bed
   - Oxygen equipment
   - Dialysis

3. Do you *currently* require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? ☐ Yes ☑ No

4. Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: ☐ Yes ☑ No
   - Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease)
   - Systemic Lupus Disease
   - Alzheimer's Disease
   - Dementia/Senility
   - Mental Retardation
   - Psychosis
   - Stroke (CVA) within past 5 years
   - Multiple Sclerosis (MS)
   - Muscular Dystrophy
   - Parkinson's Disease
   - Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test
   - Metastatic Cancer
   - Type I (Juvenile) Diabetes
   - Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day
   - A Transient Ischemic Attack (TIA) within past 2 years, *or* multiple TIAs within past 5 years
   - Chronic Kidney/Renal Disease
   - Huntington's Chorea
   - Cirrhosis of the Liver
   - Organ Transplant
   - Amputation due to Disease (not accident)

5. Are you *currently* receiving Social Security Disability benefits? ☐ Yes ☑ No

If you answered "**Yes**" to any part of any question in Section A, **PLEASE DO NOT CONTINUE.**
We regret that we cannot offer you long term care insurance coverage.
If your circumstances change, you may consider reapplying at a future time.

If you answered "**No**" to all questions in Section A, please **CONTINUE.**

Section B: Applicant Information

Employer/Group Name: ABC Company Group Number: 00001

Check ONLY one box below:

I, the applicant, am:

- ☑ an **employee** who regularly works [15] [20] [25] [30] or more hours per week for the employer named above.
  I am actively-at-work, which means I was working at my usual place of employment on the last regularly scheduled workday before I completed this application. My date of hire was: 01/01/2005 (month/year)
- ☐ a **spouse or domestic partner** of an eligible employee of the employer named above.
  His/her date of hire was: _____ (month/year)
- ☐ a **family member** of an eligible employee, or a **retiree/spouse,** or a **part-time employee/spouse** (who regularly works less than [15] [20] [25] [30] hours per week), of the employer named above.

❖ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

John _____ Doe _____
Name (First) (MI) (Last) (Suffix)

1234 Main Street _____
Street Address Apt #

Anytown ST 12345
City State Zip Code

01/01/1954
Date of Birth (mm/dd/yyyy)

123 - 56 - 7756 _____-_____
Social Security Number OR Tax Identification #

Gender:

☑ Male ☐ Female

Martial Status:

☐ Single ☑ Married ☐ Domestic Partner

810-659-2356 810-235-6593
Work Phone Number Home Phone Number

Best Time to Call: 9 a.m. 5 p.m.

Best Place to Call: ☑ Work ☐ Home

johnd@yahoo.com _____
E-mail Address Employee Number (if applicable)

Section C: Spouse Or Domestic Partner Information

PLEASE COMPLETE THE INFORMATION BELOW WHETHER OR NOT YOUR SPOUSE OR DOMESTIC PARTNER IS APPLYING. You may qualify for a couple's discount.

☐ Mr. ☑ Mrs. ☐ Ms. ☐ Dr.

Jane		Doe	
Name (First)	(MI)	(Last)	(Suffix)

125 - 95 - 1236
Social Security Number OR Tax Identification #

Is your spouse or domestic partner also applying for coverage? ☐ Yes ☑ No

Section D: Coverage Selections

BENEFIT BANK: Enter a dollar amount between $75,000 and $1,000,000 $75,000.

Note: If you request a Benefit Bank amount greater than [$400,000], you will be required to complete sections F, G and H of this application.

MONTHLY BENEFIT ACCESS LIMIT:

☑ 1% of Benefit Bank ☐ 2% of Benefit Bank ☐ 3% of Benefit Bank*

* 3% choice not available for Benefit Bank amounts greater than $500,000.

Your initial Monthly Benefit Access Limit dollar amount: $ 75,000 (Benefit Bank) x 1 % = $ 750 (Monthly Benefit)

MONEY-BACK PROMISE OPTION:

☑ Yes. I elect the Money-Back Promise Option as part of my coverage.

This optional benefit provides for a refund of a percentage of premiums (less benefits paid) to a beneficiary of your choice if you should die while holding your policy for 5 or more years.

Please enter the name of a primary and a contingent beneficiary who should receive such a refund, if any. Please note: If no beneficiary is named, any applicable refund (if any) will be made to your estate.

Primary Beneficiary ☑ Check here if this is your Spouse or Domestic Partner

☐ Mr. ☑ Mrs. ☐ Ms. ☐ Dr.

Jane (Name (First)) _____ (MI) Doe (Last) _____ (Suffix)

Wife
Relationship

1234 Main Street (Street Address) _____ (Apt #)

Anytown (City) ST (State) 12345 (Zip Code)

Contingent Beneficiary ☑ Check here if this is your Spouse or Domestic Partner

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

_____ (Name (First)) _____ (MI) _____ (Last) _____ (Suffix)

_____
Relationship

_____ (Street Address) _____ (Apt #)

_____ (City) _____ (State) _____ (Zip Code)

☐ No. I reject the Money-Back Promise Option as part of my coverage.

OPTIONAL AUTOMATIC INFLATION PROTECTION: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. Specifically, I have reviewed options for 5% and 3% Automatic Compound Inflation Protection. My choice is as follows:

- ☐ I reject the Automatic Compound Inflation Protection options; however, I understand that my coverage will include the Guaranteed Future Purchase Offers feature.
- ☑ I elect Automatic 5% Compound Inflation Protection.
- ☐ I elect Automatic 3% Compound Inflation Protection.

OPTIONAL LAPSE PROTECTION BENEFIT:

- ☑ Yes. I elect to have the Lapse Protection Benefit as part of my coverage.
- ☐ No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit.

PREMIUM PAYMENT OPTIONS:

- ☑ Lifetime Payment Option
- ☐ 10-Year Premium Payment Option*
- ☐ To-Age-65 Premium Payment Option*

* These two limited-payment options are available only if you elected Automatic 5% Compound Inflation Protection or Automatic 3% Compound Inflation Protection as part of your coverage.

Section E: Premium Payment Authorization

Complete this section to authorize your preferred premium payment method.

☐ **AUTOMATIC PAYROLL DEDUCTION** (applicable only for participating employers)

By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll.

Payroll System/Division: _____

Payroll Location: _____

Payroll Frequency: _____

Employee Number: _____

OR

☑ **DIRECT-BILLING (MAIL)**

Select one billing frequency:

☐ annually ☑ semi-annually ☐ quarterly ☐ monthly ($2.00 monthly fee applicable)

OR

☐ **MONTHLY ELECTRONIC FUNDS TRANSFER**

How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement:

I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated below, for any reason.

Name of Bank: _____

Bank Address: _____

Telephone #: _____

Account Type: ☐ checking ☐ savings

Account #: _____

Routing #: _____

OR

☐ **AUTOMATIC CREDIT CARD PAYMENT**

Select Card Type: [☐ Visa] [☐ MasterCard] [☐ American Express] [☐ Discover Card]

Credit Card #: _____

Name as it appears on Card: _____

Expiration Date: _____

DO NOT COMPLETE THIS SECTION IF YOU QUALIFY FOR SIMPLIFIED ISSUE.

Refer to Simplified Issue Qualifications.

Section F: Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (i.e., the physician with most of your medical records).

James _____ _____ Smith _____ _____
Physician's Name (First) (MI) (Last) (Suffix)

5689 First Street _____ 500 _____
Street Address Suite #

Anytown _____ ST _____ 12345 _____
City State Zip Code

810-256-8956 _____
Office Phone Number

Have you seen this physician in the last two years? ☑ Yes ☐ No

Date of last visit: 01/2009 _____
month/year

Reason for visit:

Annual Physical _____

_____

_____

DO NOT COMPLETE THIS SECTION IF YOU QUALIFY FOR SIMPLIFIED ISSUE.

Refer to Simplified Issue Qualifications.

Section G: Medical History

1. In the *past 3 years*, have you received medical advice or treatment, been diagnosed by or consulted with a healthcare professional for any of the following conditions (check all that apply or NONE OF THE ABOVE).

- ☑ 1. Drug or Alcohol Abuse
- ☐ 2. Disorders of Vision or Speech
- ☐ 3. Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease
- ☐ 4. Heart Attack, Angioplasty or Heart Surgery
- ☐ 5. Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery
- ☐ 6. Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker
- ☐ 7. Aneurysm, Peripheral Vascular Disease (PVD)
- ☐ 8. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis
- ☐ 9. Fainting Spells or Blacking Out, Seizures, Epilepsy
- ☐ 10. Tremor, Myasthenia Gravis
- ☐ 11. Paralysis (partial or full), Post Polio Syndrome
- ☐ 12. Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma
- ☐ 13. Depression, Schizophrenia, or other forms of Mental Illness
- ☐ 14. Diabetes, Disease of the Pancreas or other glands
- ☐ 15. Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease
- ☐ 16. Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement
- ☐ 17. Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone
- ☐ 18. Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease

☐ NONE OF THE ABOVE

Please give details below to all boxes checked in Question #1 of this section.
If you need more space, please attach an additional sheet of paper.

Number	Dates From/To	Physician's Name/Address/Phone	Describe
01	01/1985 to 01/2006	James Smith, Anytown, ST 12345 810-256-8956	Prescription Drug Abuse

2. In the *past 3 years*, have you had any symptoms or knowledge of any other health condition that is not disclosed above? ☑ Yes ☐ No

   If "Yes", please describe.

   Acid Reflux

3. In the *past 3 years,* have you:

   a. taken any prescription medications (if "Yes", please list)? ☑ Yes ☐ No

Medication	Dosage	Reason
Nexium	50 MG	Acid Reflux

   b. been confined in or advised to enter a hospital or rehabilitation facility? ☑ Yes ☐ No

   If "Yes", please explain and include dates and reasons.

   01/1986 Rehab Clinic for Prescription Drug Abuse

c. consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? ☑ Yes ☐ No

If "Yes", please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City & State	Specialty	Reason(s)	Dates
Dave Jones	Anytown, ST	Gastro Interology	Acid Reflux	01/2000

d. been advised by a healthcare professional to have a special evaluation testing or a surgery that has not been performed? ☑ Yes ☐ No

If "Yes", please explain type, reason and scheduled date of the evaluation, testing or surgery.
Endoscopy, Not Scheduled

e. required assistance with shopping, using transportation, housekeeping, cooking or taking medications? ☑ Yes ☐ No

If "Yes", please explain and include dates and reasons.
Can't Drive

DO NOT COMPLETE THIS SECTION IF YOU QUALIFY FOR SIMPLIFIED ISSUE.

Refer to Simplified Issue Qualifications.

Section H: Applicant Profile

1. Please provide your height 6 ft 2 in (ft. & in.) and weight 250 (lbs.)

2. In the *past 3 years*, have you used any form of tobacco or nicotine product? ☑ Yes ☐ No

Date last used	List types of tobacco or nicotine products used
05/18/2009	Cigarette

3. Do you work 20 or more hours a week outside your home? ☑ Yes ☐ No
If "Yes", please list your occupation: Financial Analysist

4. Do you drive an automobile? ☐ Yes ☑ No
If "Yes", please provide approximate annual mileage: _____ miles

5. With whom do you live? ☐ alone ☑ spouse ☐ family ☐ other

6. Do you live in some form of a residential retirement community? ☑ Yes ☐ No
If "Yes", please list the specific services that you are receiving (e.g., housekeeping, laundry, meals).
Driving, Laundry

7. In the *past 3 years*, have you had any nursing home or long term care insurance application denied? ☑ Yes ☐ No
If "Yes", by which company?
MetLife

Section I: Protection Against Unintended Lapse or Termination

I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand that notice will not be given to this person until 30 days after a premium is due and unpaid.

Please check one of the following:

☐ I elect NOT to designate another person to receive this notice.

☑ I elect to designate another person to receive this notice.

Complete the information below ONLY if you elect to name an authorized person.

Jane _____ _____ Doe _____ _____
Name (First) (MI) (Last) (Suffix)

1234 Main Street _____
Street Address **Apt #**

Anytown _____ ST _____ 12345 _____
City **State** **Zip Code**

810-235-6598 _____
Phone Number

You may change the named designee at any time by notifying us in writing at the following address:
LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

Section J: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage.

All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? ☑ Yes ☐ No

   If "Yes", provide details:

   Company Name: John Handcock

   Individual or Group Policy Number: 012562356

   Type of Coverage: Long Term Care

2. Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? ☑ Yes ☐ No

   If "Yes", provide details:

   Company Name: MetLife

   If that policy lapsed, when did it lapse? 01/2008

3. Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? ☑ Yes ☐ No

   If "Yes", provide details:

   Company Name: MetLife

   Company Address: 1245 Granger, Anytown, ST 12345

   -OR-

   Individual or Group Policy Number: 0152365

4. Are you currently covered by Medicaid? (not a reference to Medicare) ☑ Yes ☐ No

LEAVE THIS PAGE WITH THE APPLICANT.

DO NOT SUBMIT WITH APPLICATION.

Section K: Other Notices To Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau
P.O. Box 105, Essex Station
Boston, Massachusetts 02111
866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116

info@YourLifeSecure.com

TELEPHONE INTERVIEW INFORMATION

To help process your application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona**: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of **DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

To residents of **Kentucky:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To residents of **New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

To the residents of **Oklahoma:** WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony.

Section L: Applicant Authorizations and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- ☑ I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance*.
- ☑ I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Warning which appear in Section K of this Application.
- ☑ I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- ☑ I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- ☑ I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
- ☐ I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- ☑ I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section I of this Application.
- ☑ I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- ☑ I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION J OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

☑ I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance. That particular notice was delivered to me on: 05/02/2009.

I certify that I have read, or have had read to me, the competed Application.

Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy.

I understand that I, or my authorized representative, may request to receive a copy of this authorization.

My signature below represents my acknowledgement, acceptance and authorization of all statements checked above.

John Doe
Applicant's Name

01/01/1954
Date of Birth

Applicant's Signature

7756
Last 4 Digits of SSN

I certify that I have signed the application in: Anytown, ST
City, State

on Date: 05/18/2009

Section M: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my application for long term care insurance – specifically, for purposes of underwriting, servicing and claims (**in OK:** health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (**in AZ,** 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my application for long term care insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

My signature below represents my acknowledgement, acceptance and authorization for all statements above.

John Doe
Applicant's Name

01/01/1954
Date of Birth

Applicant's Signature

7756
Last 4 Digits of SSN

Signed at: Anytown, St
City, State

on Date: 05/18/2009

Section N: Agent's Report, Certification and Signature

How long have you known the applicant? _____

1. Did you personally see the applicant on the date of this application, ask each question, and accurately record the answers yourself? ☑ Yes ☐ No

   If "No", please provide details in the "Remarks" section below.

2. Are you aware of any information that would adversely affect the applicant's eligibility, acceptability, or insurability? ☑ Yes ☐ No

   If "Yes", please provide details in the "Remarks" section below.

3. Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? ☑ Yes ☐ No

   If "Yes", please provide details in the "Remarks" section below.

4. Please list other health insurance policies sold by you to the applicant:
   N/A

5. Please list other health insurance policies sold by you to the applicant in the last five years that are no longer in force.
   John Hancock Long Term Care

6. Please list all policies that the applicant has in force:
   MetLife

7. Is this policy intended to replace any of the above listed policies or any other long term care, medical or health insurance? ☑ Yes ☐ No

   Remarks
   He is a smoker and has a bad Hand Tremor.

8 If this application is approved, the Policy Welcome Kit should be sent to the:

☑ Policyholder

☐ Sales Agent (Select Agent Name in Case Split Information section on next page, if applicable.)

If sent to the Policyholder, please select an address:

☑ Policyholder Home Address (listed in Section B)

☐ New Shipping Address:

_____ _____ _____ _____
Name (First) (MI) (Last) (Suffix)

_____ _____
Street Address Apt #

_____ _____ _____
City State Zip Code

_____
Phone Number

☑ I have truthfully and accurately recorded the information supplied to me by the applicant for completion of this application.

☑ I have provided the applicant copies, either printed or electronic, of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance.*

☑ I have provided the applicant a copy of the Personal Worksheet and have explained the importance of completing the information on their Personal Worksheet.

CHECK THE BOX BELOW ONLY IF THE APPLICANT SPECIFIED IN SECTION G OF THIS APPLICATION THAT HE/SHE PLANS TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

☑ I acknowledge that I have provided the applicant with the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.

Case Split Information (if applicable)

Check one box for Agent to receive Welcome Kit

☑ Agent Name Martin Long % Split 100

Agent License # 1256892222 Contract #: 00000123

LifeSecure ID # 00000001

☐ Agent Name _____ % Split _____

Agent License # _____ Contract #: _____

LifeSecure ID # _____

☐ Agent Name _____ % Split _____

Agent License # _____ Contract #: _____

LifeSecure ID # _____

100%

100%

I certify that the applicant has read, or I have read to the applicant, the completed Application. The applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the Policy.

_____ 05/18/2009

Soliciting Agent's Signature Date

Martin _____ Long

Soliciting Agent's Name (First) (MI) (Last)

00000001 1256892222

LifeSecure ID # Agent License #

00000123

Contract #

LTC Application: Section A B C D E F G H I J K L M N | Next

Section A: Personal Health History

1. Within the *past 12 months*, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of Long Term Care Facility? Or, within the *past 12 months*, have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? ☐ Yes ☒ No

2. Do you *currently* use any of the following: ☐ Yes ☒ No
   - Walker
   - Wheelchair
   - Quad Cane
   - Motorized scooter
   - Hospital bed
   - Oxygen equipment
   - Dialysis

3. Do you *currently* require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? ☐ Yes ☒ No

4. Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: ☐ Yes ☒ No
   - Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease)
   - Systemic Lupus Disease
   - Alzheimer's Disease
   - Dementia/Senility
   - Mental Retardation
   - Psychosis
   - Stroke (CVA) within past 5 years
   - Multiple Sclerosis (MS)
   - Muscular Dystrophy
   - Parkinson's Disease
   - Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test
   - Metastatic Cancer
   - Type I (Juvenile) Diabetes
   - Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day
   - A Transient Ischemic Attack (TIA) within past 2 years, *or* multiple TIAs within past 5 years
   - Chronic Kidney/Renal Disease
   - Huntington's Chorea
   - Cirrhosis of the Liver
   - Organ Transplant
   - Amputation due to Disease (not accident)

5. Are you *currently* receiving Social Security Disability benefits? ☐ Yes ☒ No

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LTC Application: Section A B C D E F G H I J K L M N

Section B: Applicant Information

Employer/Group Name: ABC COMPANY

Group Number: 00001

Check ONLY one box below:

I, the applicant, am:

- [x] an **employee** who regularly works [15] [20] [25] [30] or more hours per week for the employer named above. I am actively-at-work, which means I was working at my usual place of employment on the last regularly scheduled workday before I completed this application.

  My date of hire was: 01/01/2005 month/year

- [ ] a **spouse or domestic partner** of an eligible employee of the employer named above.

  His/her date of hire was: month/year

- [ ] a **family member** of an eligible employee, or a **retiree/spouse**, or a **part-time employee/spouse** (who regularly works less than [15] [20] [25] [30] hours per week), of the employer named above.

(•) Mr. ( ) Mrs. ( ) Ms. ( ) Dr.

JOHN | | DOE |
Name (First) (MI) (Last) (Suffix)

1234 Main Stree
Street Address

Apt. #

Anywhere | ST | 12345
City **State** **Zip Code**

01 / 01 / 1954 **Date of Birth** (mm/dd/yyyy)

123 - 56 - 7756 **Social Security #** **OR** - **Tax Identification #**

Gender: (•) Male ( ) Female

Marital Status: ( ) Single (•) Married ( ) Domestic Partner

810 - 659 - 2356
Work Phone Number

810 - 235 - 6598
Home Phone Number

Best Time to Call: 9 a.m. 5 p.m.

Best Place to Call: (•) Work ( ) Home

JOHND@YAHOO.COM
E-mail Address

Employee Number (if applicable)

Reset Next

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LTC Application: Section A B C D E F G H I J K L M N

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Section C: Spouse or Domestic Partner Information

PLEASE COMPLETE THE INFORMATION BELOW WHETHER OR NOT YOUR SPOUSE OR DOMESTIC PARTNER IS APPLYING. You may qualify for a couple's discount.

☐ Mr. ☑ Mrs. ☐ Ms. ☐ Dr.

JANE		DOE	
Name (First)	(MI)	(Last)	(Suffix)

125 - 95 - 5236 **Social Security #** **OR** - **Tax Identification #**

Is your spouse or domestic partner also applying for coverage? ☐ Yes ☑ No

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LTC Application: Section A B C D E F G H I J K L M N Next

Section D: Coverage Selections

BENEFIT BANK:

Enter a dollar amount between $75,000 and $1,000,000 $75,000

MONTHLY BENEFIT ACCESS LIMIT:

(•) 1% of Benefit Bank ( ) 2% of Benefit Bank ( ) 3% of Benefit Bank*

* 3% choice not available for Benefit Bank amounts greater than $500,000.

Your initial Monthly Benefit Access Limit dollar amount: $ 75,000 (Benefit Bank) X _1_% = $750 (Monthly Benefit)

MONEY-BACK PROMISE OPTION:

(•) Yes, I elect to have the Money-Back Promise Option as part of my coverage.

This optional benefit provides for a refund of a percentage of premiums (less benefits paid) to a beneficiary of your choice if you should die while holding your policy for 5 or more years.

Please enter the name of a primary and a contingent beneficiary who should receive such a refund, if any. Please Note: If no beneficiary is named, any applicable refund (if any) will be made to your estate.

Primary Beneficiary [x] Check here if this is your Spouse or Domestic Partner

( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr.

Name (First) (MI) (Last) (Suffix)

Relationship

Street Address

City **State** **Zip Code**

Contingent Beneficiary [x] Check here if this is your Spouse or Domestic Partner

( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr.

Name (First) (MI) (Last) (Suffix)

Relationship

Street Address

City **State** **Zip Code**

( ) No. I reject the Money-Back Promise Option as part of my coverage.

OPTIONAL AUTOMATIC INFLATION PROTECTION: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. Specifically, I have reviewed options for 5% and 3% Automatic Compound Inflation Protection. My choice is as follows:

[ ] I reject the Automatic Compound Inflation Protection options; however, I understand that my coverage will include the Guaranteed Future Purchase Offers feature.

[x] I elect Automatic 5% Compound Inflation Protection.

[ ] I elect Automatic 3% Compound Inflation Protection.

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Application

Saved Application

Quote Calculator

Resource Center

OPTIONAL LAPSE PROTECTION BENEFIT:

- (•) Yes. I elect to have the Lapse Protection Benefit as part of my coverage.
- ( ) No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit.

Premium Payment Options: Lifetime

Total Monthly Premium[**]: $ 750

[** If the employer stops contributing to your long term care insurance coverage for any reason in the future, the Total Monthly Premium represents the full amount of monthly premium that is required to keep your policy in force.]

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LTC Application: Section A B C D E F G H I J K L M N

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Section E: Premium Payment Authorization

Complete this section to authorize your preferred premium payment method.

☐ **AUTOMATIC PAYROLL DEDUCTION**

By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll.

Payroll System/Division: _____

Payroll Location: _____

Payroll Frequency: _____

Employee Number: _____

☉ **DIRECT BILLING (MAIL)**

Select billing frequency:

☐ annually ☉ semi-annually ☐ quarterly ☐ monthly ($2.00 monthly fee applicable)

☐ **MONTHLY ELECTRONIC FUNDS TRANSFER**

How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement:

I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written Notice, if any debt is not paid by the bank stated below, for any reason.

Name of Bank: _____

Bank Address: _____

Telephone #: ___ - ___ - ____

Account Type: ☐ checking ☐ savings

Account #: _____

Routing #: _____

☐ **AUTOMATIC CREDIT CARD PAYMENT**

Select Card Type: [☐ Visa] [☐ MasterCard] [☐ American Express] [☉ Discover Card]

Credit Card #: _____ (do not enter dashes or spaces)

Name as it appears on Card: _____

Expiration Date: ___ / ___

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LTC Application: Section A B C D E F G H I J K L M N

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Section F: Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (i.e., the physician with most of your medical records).

JAMES | | SMITH |

Physician's Name (First) (MI) (Last) (Suffix)

5689 1ST STREET

Street Address

500

Suite #

ANYTOWN | ST | 12345

City **State** **Zip Code**

810 - 256 - 8956

Office Phone Number

Have you seen this physician in the last two years? (•) Yes ( ) No

Date of last visit: 01 / 09

month year

Reason for visit: ANNUAL PHYSICAL

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LTC Application: Section A B C D E F G H I J K L M N | Next

Section G: Medical History (Part 1)

1. In the *past 3 years*, have you received medical advice or treatment, been diagnosed by or consulted with a healthcare professional for any of the following conditions (check all that apply or NONE OF THE ABOVE).

- [x] 1. Drug or Alcohol Abuse
- [ ] 2. Disorders of Vision or Speech
- [ ] 3. Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease
- [ ] 4. Heart Attack, Angioplasty or Heart Surgery
- [ ] 5. Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery
- [ ] 6. Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker
- [ ] 7. Aneurysm, Peripheral Vascular Disease (PVD)
- [ ] 8. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis
- [ ] 9. Fainting Spells or Blacking Out, Seizures, Epilepsy
- [ ] 10. Tremor, Myasthenia Gravis
- [ ] 11. Paralysis (partial or full), Post Polio Syndrome
- [ ] 12. Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma
- [ ] 13. Depression, Schizophrenia, or other forms of Psychosis or Mental Illness
- [ ] 14. Diabetes, Disease of the Pancreas or other glands
- [ ] 15. Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease
- [ ] 16. Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement
- [ ] 17. Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone
- [ ] 18. Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn’s Disease

- [ ] NONE OF THE ABOVE

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LTC Application: Section A B C D E F G H I J K L M N

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Section G: Medical History (Part 2)

Please give details below to all boxes checked in Question #1 of this section.

☑ 1. Drug or Alcohol Abuse

Dates of Condition	Physician's Name/Address/Phone	Description
From: 01/1985 To: ☐ Present Or 1/2006	☑ Same as Primary Care Doctor (Section F) name: JOHN SMITH address: 5689 1ST STREET SUITE 500 city/st/zip: ANYTOWN ST 12345 phone: 810 - 256 - 8956	PRESCRIPTION DRUG ABUSE

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LTC Application: Section A B C D E F G H I J K L M N | Next

Section G: Medical History (Part 3)

2. In the *past 3 years*, have you had any symptoms or knowledge of any other health condition that is not disclosed above? ◉ Yes ○ No

   Please describe:

   ACID REFLUX

3. In the *past 3 years*, have you:
   a. taken any prescription medications? (if yes, please list) ◉ Yes ○ No

	Medication	Dosage	Reason	
✖	NEXIUM	50 MG	ACID REFLUX	
✖				

NEXIUM | 50 MG | ACID REFLUX

Add

   b. been confined in or advised to enter a hospital or rehabilitation facility? ◉ Yes ○ No

   Please explain and include dates and reasons:

   01/1986 REHAB CLINIC FOR PRESCRIPTION DRUG ABUSE

   c. consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? If Yes, please provide the Healthcare Professional's name, location, specialty, reason consulted ○ Yes ○ No

	Name/Location/Specialty	Reason Consulted	Dates	
✖	DAVE JONES/ANYTOWN, ST/ GATSTRO INTEROLOGIST	ACID REFLUX	01/2000	
✖				

Add

   d. been advised by a healthcare professional to have a special evaluation, testing or a surgery that has not been performed? ◉ Yes ○ No

   Please explain type, reason and scheduled date of the evaluation, testing or surgery:

   e. required assistance with shopping, using transportation, housekeeping, cooking or taking medications? ◉ Yes ○ No

   Please explain and include dates and reasons:

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LTC Application: Section A B C D E F G H I J K L M N

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Section H: Applicant Profile

1. Please provide your height ____ ft. ____ in., and weight ____ lbs.

2. In the *past 3 years*, have you used any form of tobacco or nicotine product? ◉ Yes ○ No

	Date Last Used	Types of Tobacco or Nicotine Products Used	
✕	5/18/2009	cigarettes	
✕			

12/12/2005	cigarettes

Add

3. Do you work 20 or more hours a week outside your home? ◉ Yes ○ No

   Please list your occupation: Financial Analyist

4. Do you drive an automobile? ○ Yes ◉ No

   Please provide approximate annual mileage: ____ miles

5. With whom do you live?

   ◉ alone ○ spouse ○ family ○ other

6. Do you live in some form of a residential retirement community? ◉ Yes ○ No

   Please list the specific services that you are receiving (e.g., housekeeping, laundry, meals):

   Driving, Laundry

7. In the *past 3 years*, have you had any nursing home or long term care insurance application denied? ◉ Yes ○ No

   By which company?

   MetLife

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LTC Application: Section A B C D E F G H I J K L M N Next

Section [F] [I]: Protection Against Unintended Lapse or Termination

I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand that notice will not be given to this person until 30 days after a premium is due and unpaid.

Please check one of the following:

- ☐ I elect NOT to designate another person to receive this Notice.
- ☉ I elect to designate another person to receive this Notice.

Complete the information below ONLY if you elect to name an authorized person.

JANE | | DOE |

Name (First) (MI) (Last) (Suffix)

1234 MAIN ST

Street Address

Apt. #

ANYTOWN | ST | 12345

City **State** **Zip Code**

810 - 235 - 3598

Phone Number

You may change the named designee at any time by notifying us in writing at the following address: LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

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LTC Application: Section A B C D E F G H I J K L M N

Next

Section [G] [J]: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? ☑ Yes ☐ No

   Please provide the following details:

   Company Name: JOHN HANDCOCK

   Individual or Group Policy Number: 012562356

   Type of Coverage: LONG TERM CARE

2. Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? ☑ Yes ☐ No

   With which company? METLIFE

   If that policy lapsed, when did it lapse? 01/2008

3. Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? ☑ Yes ☐ No

   If "Yes", provide details:

   Company Name: METLIFE

   Company Address: 1245 GRANGER, ANYTOWN, ST

   -OR-

   Individual or Group Policy Number: 0152365

4. Are you currently covered by Medicaid? (not a reference to Medicare) ☑ Yes ☐ No

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Section [H] [K]: Other Notices to Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a Non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau
P.O. Box 105, Essex Station
Boston, Massachusetts 02111
866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116

info@YourLifeSecure.com

TELEPHONE INTERVIEW INFORMATION

To help process your Application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona**: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of **DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

To residents of **Kentucky**: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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To residents of **New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

To the residents of **Oklahoma**: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony.

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Section [I] [L]: Applicant Authorization and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- [x] I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance.*
- [x] I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Notice which appear in Section [H] [K] of this Application.
- [x] I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- [x] I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- [x] I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
- [ ] I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- [x] I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section [F] [I] of this Application.
- [x] I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- [x] I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

- [x] I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.

  That particular notice was delivered to me on: 05 / 02 / 2009

I certify that I have read, or have had read to me, the completed Application.

Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy.

I understand that I, or my authorized representative, may request to receive a copy of this authorization.

Clicking "Accept" represents my acknowledgement, acceptance and authorization of all statements checked above.

(•) **ACCEPT** ( ) **DECLINE** Date: 05 / 18 / 2009

I certify that I have signed the Application in ANYTOWN (City) ST (State)

The applicant must sign the Application by voice authorization code entry or by signature via faxed Application. Please indicate the method of signature below:

(•) Voice Authorization Code 0125623

( ) Signature Via Faxed Application

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Section [J] [M]: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for Long Term Care Insurance from LifeSecure – specifically, for purposes of underwriting, servicing and claims (**in OK**: health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (**in AZ**, 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for Long Term Care Insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

Clicking "Accept" represents my acknowledgement and understanding of all statements above.

◉ **ACCEPT** ○ **DECLINE**

Applicant's Voice Authorization Code: 0125623 Date: 05 / 18 / 2009

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Section [K] [N]: Agent's Report

How long have you known the applicant? 6 Y

Statements

1. Did you personally see the applicant on the date of this Application, ask each question, and accurately record the answers yourself? (●) Yes ( ) No
   If “No”, please provide details in the “Remarks” section below.

2. Are you aware of any information that would adversely affect the applicant’s eligibility, acceptability, or insurability? (●) Yes ( ) No
   If “Yes”, please provide details in the “Remarks” section below.

3. Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? (●) Yes ( ) No
   If “Yes”, please provide details in the “Remarks” section below.

4. Please list other health insurance policies sold by you to the applicant:

   N/A

5. Please list other health insurance policies sold by you to the applicant in the last five years that are no longer in force.

   JOHN HANDCOCK LONG TERM CARE

6. Please list all policies that the applicant has in force:

   METLIFE

7. Is this policy intended to replace any of the above listed policies or any other long term care, medical or health insurance? (●) Yes ( ) No

Remarks

HIS IS A SMOKER AND HAS A BAD HAND TREMOR

8. If this Application is approved, the Policy Welcome Kit should be sent to the:
   (●) **Policyholder** ( ) **Sales Agent** (Select Agent Name in Case Split Information section below.)

   If sent to the policyholder, please select an address:

   [x] **Policyholder Home Address** [ ] **New Shipping Address**

   Name (First) (MI) (Last) (Suffix)

   Street Address **Apt. #**

   City **State** **Zip Code**

   Phone Number

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- [x] I have truthfully and accurately recorded the information supplied to me by the applicant for completion of this Application.
- [x] I have provided the applicant copies, either printed or electronic, of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance.*
- [x] I have provided the applicant a copy of the Personal Worksheet and have explained the importance of completing the information on their Personal Worksheet.

CHECK THE BOX BELOW ONLY IF THE APPLICANT SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT HE/SHE PLANS TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

- [x] I acknowledge that I have provided the applicant with the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.

MARTIN LONG	00000001	1256892222
Soliciting Agent's Name	**LifeSecure ID#**	**Agent License #**

05 / 18 / 2009 — **Date**

1256892222 — **Contract Number**

Case Split Information (if applicable)

Check one box for Agent to receive Welcome Kit

	LifeSecure ID#	Agent Name	Agent License #	Contract#	% Split
◉	00000001	MARTIN LONG	1256892222	125	100
○					
○					
○					
○					
○					
○					
○					
○					
○					

Total: 100%

I certify that the applicant has read, or I have read to the applicant, the completed Application. The applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the Policy.

Clicking "Accept" represents my acknowledgement, acceptance and authorization for all statements above.

◉ **ACCEPT** ○ **DECLINE**

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Application

Saved Application

Quote Calculator

Resource Center

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Live Chat Session

Once you have submitted this on-line Application, you may initiate a Live Chat session to engage an underwriter to evaluate the Application responses and approve the Application, if possible.

However, if a face-to-face interview, phone history interview or request for medical records is required, please inform the applicant that it may take additional business days to fully evaluate the Application and provide a final decision. (Note: Such additional requirements are not applicable to applicants who qualify for Simplified Issue Underwriting.)

Coverage Summary

Premium Plan: **[Lifetime Payment Option]**
[10-Year Payment Option]
[To-Age-65 Option]

Benefit Bank Amount	[$75,000 - $1,000,0000]
Monthly Benefit Access Limit	[$XX,XXX] [(1%)] [(2%)] [(3%)]
Monthly Premium	[$XXX.XX]
Benefit Wait Period	[90] calendar days
Other Benefits Included	

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LifeSecure Insurance Company
10559 Citation Dr., Ste 300
Brighton, MI 48116

Section A: Personal Health History

1. Within the *past 12 months*, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of Long Term Care Facility? Or, within the *past 12 months*, have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? ☐ Yes ☑ No

2. Do you *currently* use any of the following: ☐ Yes ☑ No
   - Walker
   - Wheelchair
   - Quad Cane
   - Motorized scooter
   - Hospital bed
   - Oxygen equipment
   - Dialysis

3. Do you *currently* require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? ☐ Yes ☑ No

4. Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: ☐ Yes ☑ No
   - Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease)
   - Systemic Lupus Disease
   - Alzheimer's Disease
   - Dementia/Senility
   - Mental Retardation
   - Psychosis
   - Stroke (CVA) within past 5 years
   - Multiple Sclerosis (MS)
   - Muscular Dystrophy
   - Parkinson's Disease
   - Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test
   - Metastatic Cancer
   - Type I (Juvenile) Diabetes
   - Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day
   - A Transient Ischemic Attack (TIA) within past 2 years, *or* multiple TIAs within past 5 years
   - Chronic Kidney/Renal Disease
   - Huntington's Chorea
   - Cirrhosis of the Liver
   - Organ Transplant
   - Amputation due to Disease (not accident)

5. Are you *currently* receiving Social Security Disability benefits? ☐ Yes ☑ No

If you answered "**Yes**" to any part of any question in Section A, **PLEASE DO NOT CONTINUE.**
We regret that we cannot offer you long term care insurance coverage.
If your circumstances change, you may consider reapplying at a future time.

If you answered "**No**" to all questions in Section A, please **CONTINUE.**

Section B: Applicant Information

Employer/Group Name: ABC Company Group Number: 00001

Check ONLY one box below:

I, the applicant, am:

- ☑ an **employee** who regularly works [15] [20] [25] [30] or more hours per week for the employer named above. I am actively-at-work, which means I was working at my usual place of employment on the last regularly scheduled workday before I completed this application. My date of hire was: 01/01/2005 (month/year)
- ☐ a **spouse or domestic partner** of an eligible employee of the employer named above. His/her date of hire was: _____ (month/year)
- ☐ a **family member** of an eligible employee, or a **retiree/spouse,** or a **part-time employee/spouse** (who regularly works less than [15] [20] [25] [30] hours per week), of the employer named above.

☑ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

John | | Doe |
Name (First) | (MI) | (Last) | (Suffix)

1234 Main Street | Apt #
Street Address

Anytown | ST | 12345
City | State | Zip Code

01/01/1954
Date of Birth (mm/dd/yyyy)

123 - 56 - 7756 OR _____-_____
Social Security Number | Tax Identification #

Gender:

☑ Male ☐ Female

Martial Status:

☐ Single ☑ Married ☐ Domestic Partner

810-659-2356
Work Phone Number

810-235-6593
Home Phone Number

Best Time to Call: 9 a.m. 5 p.m.

Best Place to Call: ☑ Work ☐ Home

johnd@yahoo.com
E-mail Address

_____
Employee Number (if applicable)

Section C: Spouse Or Domestic Partner Information

PLEASE COMPLETE THE INFORMATION BELOW WHETHER OR NOT YOUR SPOUSE OR DOMESTIC PARTNER IS APPLYING. You may qualify for a couple's discount.

☐ Mr. ☑ Mrs. ☐ Ms. ☐ Dr.

Jane		Doe	
Name (First)	(MI)	(Last)	(Suffix)

125 - 95 - 1236
Social Security Number OR _____-_____
Tax Identification #

Is your spouse or domestic partner also applying for coverage? ☐ Yes ☑ No

Section D: Coverage Selections

BENEFIT BANK: Enter a dollar amount between $75,000 and $1,000,000 $75,000.

MONTHLY BENEFIT ACCESS LIMIT:

☑ 1% of Benefit Bank ☐ 2% of Benefit Bank ☐ 3% of Benefit Bank*

* 3% choice not available for Benefit Bank amounts greater than $500,000.

Your initial Monthly Benefit Access Limit dollar amount: $ 75,000 (Benefit Bank) x 1 % = $ 750 (Monthly Benefit)

MONEY-BACK PROMISE OPTION:

☑ Yes. I elect the Money-Back Promise Option as part of my coverage.

This optional benefit provides for a refund of a percentage of premiums (less benefits paid) to a beneficiary of your choice if you should die while holding your policy for 5 or more years.

Please enter the name of a primary and a contingent beneficiary who should receive such a refund, if any. Please note: If no beneficiary is named, any applicable refund (if any) will be made to your estate.

Primary Beneficiary ☑ Check here if this is your Spouse or Domestic Partner

☐ Mr. ☑ Mrs. ☐ Ms. ☐ Dr.

Jane (Name (First)) _____ (MI) Doe (Last) _____ (Suffix)

Wife
Relationship

1234 Main Street
Street Address

Apt #

Anytown
City

ST
State

12345
Zip Code

Contingent Beneficiary ☑ Check here if this is your Spouse or Domestic Partner

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name (First) (MI) (Last) (Suffix)

Relationship

Street Address

Apt #

City

State

Zip Code

☐ No. I reject the Money-Back Promise Option as part of my coverage.

OPTIONAL AUTOMATIC INFLATION PROTECTION: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. Specifically, I have reviewed options for 5% and 3% Automatic Compound Inflation Protection. My choice is as follows:

- ☐ I reject the Automatic Compound Inflation Protection options; however, I understand that my coverage will include the Guaranteed Future Purchase Offers feature.
- ☑ I elect Automatic 5% Compound Inflation Protection.
- ☐ I elect Automatic 3% Compound Inflation Protection.

OPTIONAL LAPSE PROTECTION BENEFIT:

- ☑ Yes. I elect to have the Lapse Protection Benefit as part of my coverage.
- ☐ No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit.

PREMIUM PAYMENT OPTIONS:

- ☑ Lifetime Payment Option
- ☐ 10-Year Premium Payment Option*
- ☐ To-Age-65 Premium Payment Option*

* These two limited-payment options are available only if you elected Automatic 5% Compound Inflation Protection or Automatic 3% Compound Inflation Protection as part of your coverage.

Section E: Premium Payment Authorization

Complete this section to authorize your preferred premium payment method.

☐ **AUTOMATIC PAYROLL DEDUCTION** (applicable only for participating employers)

By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll.

Payroll System/Division: _____

Payroll Location: _____

Payroll Frequency: _____

Employee Number: _____

☑ **DIRECT-BILLING (MAIL)**

Select one billing frequency:

☐ annually ☑ semi-annually ☐ quarterly ☐ monthly ($2.00 monthly fee applicable)

OR

☐ **MONTHLY ELECTRONIC FUNDS TRANSFER**

How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement:

I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated below, for any reason.

Name of Bank: _____

Bank Address: _____

Telephone #: _____

Account Type: ☐ checking ☐ savings

Account #: _____

Routing #: _____

OR

☐ **AUTOMATIC CREDIT CARD PAYMENT**

Select Card Type: [☐ Visa] [☐ MasterCard] [☐ American Express] [☐ Discover Card]

Credit Card #: _____

Name as it appears on Card: _____

Expiration Date: _____

Section F: Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (i.e., the physician with most of your medical records).

James _____ _____ Smith _____ _____
Physician's Name (First) (MI) (Last) (Suffix)

5689 First Street _____ 500 _____
Street Address Suite #

Anytown _____ ST _____ 12345 _____
City State Zip Code

810-256-8956 _____
Office Phone Number

Have you seen this physician in the last two years? ☑ Yes ☐ No

Date of last visit: 01/2009 _____
month/year

Reason for visit:

Annual Physical _____

Section G: Medical History

1. In the *past 3 years*, have you received medical advice or treatment, been diagnosed by or consulted with a healthcare professional for any of the following conditions (check all that apply or NONE OF THE ABOVE).

- [x] 1. Drug or Alcohol Abuse
- [ ] 2. Disorders of Vision or Speech
- [ ] 3. Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease
- [ ] 4. Heart Attack, Angioplasty or Heart Surgery
- [ ] 5. Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery
- [ ] 6. Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker
- [ ] 7. Aneurysm, Peripheral Vascular Disease (PVD)
- [ ] 8. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis
- [ ] 9. Fainting Spells or Blacking Out, Seizures, Epilepsy
- [ ] 10. Tremor, Myasthenia Gravis
- [ ] 11. Paralysis (partial or full), Post Polio Syndrome
- [ ] 12. Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma
- [ ] 13. Depression, Schizophrenia, or other forms of Mental Illness
- [ ] 14. Diabetes, Disease of the Pancreas or other glands
- [ ] 15. Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease
- [ ] 16. Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement
- [ ] 17. Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone
- [ ] 18. Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease

- [ ] NONE OF THE ABOVE

Please give details below to all boxes checked in Question #1 of this section.
If you need more space, please attach an additional sheet of paper.

Number	Dates From/To	Physician's Name/Address/Phone	Describe
01	01/1985 to 01/2006	James Smith, Anytown, ST 12345 810-256-8956	Prescription Drug Abuse

2. In the *past 3 years*, have you had any symptoms or knowledge of any other health condition that is not disclosed above? ☑ Yes ☐ No

   If "Yes", please describe.

   Acid Reflux

3. In the *past 3 years,* have you:

   a. taken any prescription medications (if "Yes", please list)? ☑ Yes ☐ No

Medication	Dosage	Reason
Nexium	50 MG	Acid Reflux

   b. been confined in or advised to enter a hospital or rehabilitation facility? ☑ Yes ☐ No

   If "Yes", please explain and include dates and reasons.

   01/1986 Rehab Clinic for Prescription Drug Abuse

c. consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? ☑ Yes ☐ No

If "Yes", please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City & State	Specialty	Reason(s)	Dates
Dave Jones	Anytown, ST	Gastro Interology	Acid Reflux	01/2000

d. been advised by a healthcare professional to have a special evaluation testing or a surgery that has not been performed? ☑ Yes ☐ No

If "Yes", please explain type, reason and scheduled date of the evaluation, testing or surgery.
Endoscopy, Not Scheduled

e. required assistance with shopping, using transportation, housekeeping, cooking or taking medications? ☑ Yes ☐ No

If "Yes", please explain and include dates and reasons.
Can't Drive

Section H: Applicant Profile

1. Please provide your height 6 ft 2 in (ft. & in.) and weight 250 (lbs.)

2. In the *past 3 years*, have you used any form of tobacco or nicotine product? ☑ Yes ☐ No

Date last used	List types of tobacco or nicotine products used
05/18/2009	Cigarette

3. Do you work 20 or more hours a week outside your home? ☑ Yes ☐ No
If "Yes", please list your occupation: Financial Analysist

4. Do you drive an automobile? ☐ Yes ☑ No
If "Yes", please provide approximate annual mileage: _____ miles

5. With whom do you live? ☐ alone ☑ spouse ☐ family ☐ other

6. Do you live in some form of a residential retirement community? ☑ Yes ☐ No
If "Yes", please list the specific services that you are receiving (e.g., housekeeping, laundry, meals).
Driving, Laundry

7. In the *past 3 years*, have you had any nursing home or long term care insurance application denied? ☑ Yes ☐ No
If "Yes", by which company?
MetLife

Section [F] [I]: Protection Against Unintended Lapse or Termination

I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand that notice will not be given to this person until 30 days after a premium is due and unpaid.

Please check one of the following:

☐ I elect NOT to designate another person to receive this notice.

☑ I elect to designate another person to receive this notice.

Complete the information below ONLY if you elect to name an authorized person.

Jane		Doe	
Name (First)	(MI)	(Last)	(Suffix)

1234 Main Street	
Street Address	**Apt #**

Anytown	ST	12345
City	**State**	**Zip Code**

810-235-6598
Phone Number

You may change the named designee at any time by notifying us in writing at the following address:
LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

Section [G] [J]: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage.

All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? ☑ Yes ☐ No

   If "Yes", provide details:

   Company Name: John Handcock

   Individual or Group Policy Number: 012562356

   Type of Coverage: Long Term Care

2. Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? ☑ Yes ☐ No

   If "Yes", provide details:

   Company Name: MetLife

   If that policy lapsed, when did it lapse? 01/2008

3. Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? ☑ Yes ☐ No

   If "Yes", provide details:

   Company Name: MetLife

   Company Address: 1245 Granger, Anytown, ST 12345

   -OR-

   Individual or Group Policy Number: 0152365

4. Are you currently covered by Medicaid? (not a reference to Medicare) ☑ Yes ☐ No

Section [H] [K]: Other Notices To Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau
P.O. Box 105, Essex Station
Boston, Massachusetts 02111
866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116

info@YourLifeSecure.com

TELEPHONE INTERVIEW INFORMATION

To help process your Application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona**: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an Application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of **DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

To residents of **Kentucky:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an Application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To residents of **New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

To the residents of **Oklahoma:** WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an Application containing false, incomplete, or misleading information is guilty of a felony.

Section [I] [L]: Applicant Authorizations and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- ☑ I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance.*
- ☑ I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Warning which appear in Section K of this Application.
- ☑ I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- ☑ I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- ☑ I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
- ☐ I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- ☑ I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section I of this Application.
- ☑ I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- ☑ I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

☑ I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance. That particular notice was delivered to me on: 05/02/2009.

I certify that I have read, or have had read to me, the competed Application.

Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy.

I understand that I, or my authorized representative, may request to receive a copy of this authorization.

Clicking "Accept" represents my acknowledgement, acceptance and authorization of all statements checked above.

☑ **ACCEPT** ☐ **DECLINE** **Date:** 05/18/2009

I certify that I have signed the Application in: Anytown, ST
City, State

The applicant must sign the Application by voice authorization code entry or by signature via faxed Application.

Please indicate the method of signature below:

☑ **Voice Authorization Code** 052365

☐ **Signature Via Faxed Application**

Section [J] [M]: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for long term care insurance – specifically, for purposes of underwriting, servicing and claims (**in OK:** health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (**in AZ,** 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for long term care insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

Clicking "Accept" represents my acknowledgement and understanding of all statements above.

☑ **ACCEPT** ☐ **DECLINE**

Applicant's Voice Authorization Code: 052365 **Date:** 05/18/2009

Section [K] [N]: Agent's Report, Certification and Signature

How long have you known the applicant? _____

1. Did you personally see the applicant on the date of this application, ask each question, and accurately record the answers yourself? ☑ Yes ☐ No

   If "No", please provide details in the "Remarks" section below.

2. Are you aware of any information that would adversely affect the applicant's eligibility, acceptability, or insurability? ☑ Yes ☐ No

   If "Yes", please provide details in the "Remarks" section below.

3. Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? ☑ Yes ☐ No

   If "Yes", please provide details in the "Remarks" section below.

4. Please list other health insurance policies sold by you to the applicant:
   N/A

5. Please list other health insurance policies sold by you to the applicant in the last five years that are no longer in force.
   John Hancock Long Term Care

6. Please list all policies that the applicant has in force:
   MetLife

7. Is this policy intended to replace any of the above listed policies or any other long term care, medical or health insurance? ☑ Yes ☐ No

   Remarks
   He is a smoker and has a bad Hand Tremor.

8 If this application is approved, the Policy Welcome Kit should be sent to the:

☑ Policyholder

☐ Sales Agent (Select Agent Name in Case Split Information section on next page, if applicable.)

If sent to the Policyholder, please select an address:

☑ Policyholder Home Address (listed in Section B)

☐ New Shipping Address:

_____ _____ _____ _____
Name (First) (MI) (Last) (Suffix)

_____ _____
Street Address Apt #

_____ _____ _____
City State Zip Code

_____
Phone Number

☑ I have truthfully and accurately recorded the information supplied to me by the applicant for completion of this Application.

☑ I have provided the applicant copies, either printed or electronic, of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance.*

☑ I have provided the applicant a copy of the Personal Worksheet and have explained the importance of completing the information on their Personal Worksheet.

CHECK THE BOX BELOW ONLY IF THE APPLICANT SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT HE/SHE PLANS TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

☑ I acknowledge that I have provided the applicant with the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.

Martin _____ Long
Soliciting Agent's Name (First) **(MI)** **(Last)**

00000001 1256892222
LifeSecure ID # **Agent License #**

00000123 05/18/2009
Contract # **Date**

Case Split Information (if applicable)

Check one box for Agent to receive Welcome Kit

☑ Agent Name Martin Long % Split 100

Agent License # 1256892222 Contract #: 00000123

LifeSecure ID # 00000001

☐ Agent Name _____ % Split _____

Agent License # _____ Contract #: _____

LifeSecure ID # _____

☐ Agent Name _____ % Split _____

Agent License # _____ Contract #: _____

LifeSecure ID # _____

100%

100%

I certify that the applicant has read, or I have read to the applicant, the completed Application. The applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the Policy.

Clicking "Accept" represents my acknowledgement, acceptance and authorization for all statements above.

☑ **ACCEPT** ☐ **DECLINE**

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Section A: Personal Health History

1. Within the *past 12 months*, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of Long Term Care Facility? Or, within the *past 12 months*, have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? ☐ Yes ☒ No

2. Do you *currently* use any of the following: ☐ Yes ☒ No
   - Walker
   - Wheelchair
   - Quad Cane
   - Motorized scooter
   - Hospital bed
   - Oxygen equipment
   - Dialysis

3. Do you *currently* require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? ☐ Yes ☒ No

4. Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: ☐ Yes ☒ No
   - Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease)
   - Systemic Lupus Disease
   - Alzheimer's Disease
   - Dementia/Senility
   - Mental Retardation
   - Psychosis
   - Stroke (CVA) within past 5 years
   - Multiple Sclerosis (MS)
   - Muscular Dystrophy
   - Parkinson's Disease
   - Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test
   - Metastatic Cancer
   - Type I (Juvenile) Diabetes
   - Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day
   - A Transient Ischemic Attack (TIA) within past 2 years, *or* multiple TIAs within past 5 years
   - Chronic Kidney/Renal Disease
   - Huntington's Chorea
   - Cirrhosis of the Liver
   - Organ Transplant
   - Amputation due to Disease (not accident)

5. Are you *currently* receiving Social Security Disability benefits? ☐ Yes ☒ No

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Section B: Applicant Information

Employer/Group Name: ABC Company

Group Number: 00001

Check ONLY one box below:

I, the applicant, am:

☑ an **employee** who regularly works [15] [20] [25] [30] or more hours per week for the employer named above. I am actively-at-work, which means I was working at my usual place of employment on the last regularly scheduled workday before I completed this application.

My date of hire was: 01/01/2005
month/year

☐ a **spouse or domestic partner** of an eligible employee of the employer named above.

His/her date of hire was:
month/year

☐ a **family member** of an eligible employee, or a **retiree/spouse**, or a **part-time employee/spouse** (who regularly works less than [15] [20] [25] [30] hours per week), of the employer named above.

◉ Mr. ○ Mrs. ○ Ms. ○ Dr.

John | | Doe |
Name (First) (MI) (Last) (Suffix)

1234 Mian Street
Street Address

Apt. #

Anytown | ST
City **State** **Zip Code**

01 / 01 / 1954 | 123 - 56 - 7756 | - |
Date of Birth (mm/dd/yyyy) **Social Security #** **OR** **Tax Identification #**

Gender: ◉ Male ○ Female

Marital Status: ○ Single ◉ Married ○ Domestic Partner

810 - 659 - 2356
Work Phone Number

810 - 235 - 6593
Home Phone Number

Best Time to Call: 9 a.m. 5 p.m.

Best Place to Call: ◉ Work ○ Home

JOHND@YAHOO.COM
E-mail Address

JOHND@YAHOO.COM
Verify E-mail Address

Employee Number (if applicable)

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1. Please select your **User Name** and **Password**. You'll use these to log onto the Policyholders Portal after your policy is approved. You'll also use your user name and password to log back onto the Group & Associations Portal to complete your application should you decide to save it and finish it later. The user name and password must be between 6 and 16 characters long and can contain only letters and numbers. Password must contain at least one number.

User Name	Password	Confirm Password
johnd	jandj	jandj

2. Next please enter a **Security Question** and the **correct answer** to the question. We will ask you this question if you forget your password. A correct answer will enable you to select a new password.

Security Question: What w as your first pet?

Security Answer: Dog

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Section C: Spouse or Domestic Partner Information

PLEASE COMPLETE THE INFORMATION BELOW WHETHER OR NOT YOUR SPOUSE OR DOMESTIC PARTNER IS APPLYING. You may qualify for a couple's discount.

☐ Mr. ☉ Mrs. ☐ Ms. ☐ Dr.

Jane		Doe	
Name (First)	(MI)	(Last)	(Suffix)

125 - 95 - 1236 **Social Security #** **OR** - **Tax Identification #**

Is your spouse or domestic partner also applying for coverage? ☐ Yes ☉ No

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Section D: Coverage Selections

BENEFIT BANK:

Enter a dollar amount between $75,000 and $1,000,000 $75,000

MONTHLY BENEFIT ACCESS LIMIT:

☐ 1% of Benefit Bank ☐ 2% of Benefit Bank ☐ 3% of Benefit Bank*

* 3% choice not available for Benefit Bank amounts greater than $500,000.

Your initial Monthly Benefit Access Limit dollar amount: $ $75,000 (Benefit Bank) X _1_ % = $750 (Monthly Benefit)

MONEY-BACK PROMISE OPTION:

☑ Yes, I elect to have the Money-Back Promise Option as part of my coverage.

This optional benefit provides for a refund of a percentage of premiums (less benefits paid) beneficiary of your choice if you should die while holding your policy for 5 or more years.

Please enter the name of a primary and a contingent beneficiary who should receive such a refund, if any.
Please Note: If no beneficiary is named, any applicable refund will be made to your estate.

Primary Beneficiary ☑ Check here if this is your Spouse or Domestic Partner

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Jane | | Doe |
Name (First) (MI) (Last) (Suffix)

Wife
Relationship

1234 Main Street
Street Address

Anytown | ST |
City **State** **Zip Code**

Contingent Beneficiary ☑ Check here if this is your Spouse or Domestic Partner

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

| | |
Name (First) (MI) (Last) (Suffix)

Relationship

Street Address

| | |
City **State** **Zip Code**

☐ No. I reject the Money-Back Promise Option as part of my coverage.

OPTIONAL AUTOMATIC INFLATION PROTECTION: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. Specifically, I have reviewed options for 5% and 3% Automatic Compound Inflation Protection. My choice is as follows:

☐ I reject the Automatic Compound Inflation Protection options; however, I understand that my covera will include the Guaranteed Future Purchase Offers feature.

☑ I elect Automatic 5% Compound Inflation Protection.

☐ I elect Automatic 3% Compound Inflation Protection.

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OPTIONAL LAPSE PROTECTION BENEFIT:

- (•) Yes. I elect to have the Lapse Protection Benefit as part of my coverage.
- ( ) No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit.

Premium Payment Options: Lifetime

Total Monthly Premium[**]: $ 750

[If the employer stops contributing to your long term care insurance coverage for any reason in the future, the Total Monthly Premium represents the full amount of monthly premium that is required to keep your policy in force.]**

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Section E: Premium Payment Authorization

Complete this section to authorize your preferred premium payment method.

☐ **AUTOMATIC PAYROLL DEDUCTION**

By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll.

Payroll System/Division:

Payroll Location:

Payroll Frequency:

Employee Number:

☉ **DIRECT BILLING (MAIL)**

Select billing frequency:

☐ annually ☉ semi-annually ☐ quarterly ☐ monthly ($2.00 monthly fee applicable)

☐ **MONTHLY ELECTRONIC FUNDS TRANSFER**

How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement:

I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written Notice, if any debt is not paid by the bank stated below, for any reason.

Name of Bank:

Bank Address:

Telephone #: - -

Account Type: ☐ checking ☐ savings

Account #:

Routing #:

☐ **AUTOMATIC CREDIT CARD PAYMENT**

Select Card Type: [☐ Visa] [☐ MasterCard] [☐ American Express] [☐ Discover Card]

Credit Card #: (do not enter dashes or spaces)

Name as it appears on Card:

Expiration Date: /

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Section F: Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (i.e., the physician with most of your medical records).

James | | Smith |

Physician's Name (First) (MI) (Last) (Suffix)

5689 First Street

Street Address

500

Suite #

Anytown | ST

City **State** **Zip Code**

810 - 256 - 8956

Office Phone Number

Have you seen this physician in the last two years? (•) Yes ( ) No

Date of last visit: 01 / 2009

month year

Reason for visit:

Annual Physical

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Section G: Medical History (Part 1)

1. In the *past 3 years*, have you received medical advice or treatment, been diagnosed by or consulted with a healthcare professional for any of the following conditions (check all that apply or NONE OF THE ABOVE).

- [x] 1. Drug or Alcohol Abuse
- [ ] 2. Disorders of Vision or Speech
- [ ] 3. Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease
- [ ] 4. Heart Attack, Angioplasty or Heart Surgery
- [ ] 5. Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery
- [ ] 6. Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker
- [ ] 7. Aneurysm, Peripheral Vascular Disease (PVD)
- [ ] 8. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis
- [ ] 9. Fainting Spells or Blacking Out, Seizures, Epilepsy
- [ ] 10. Tremor, Myasthenia Gravis
- [ ] 11. Paralysis (partial or full), Post Polio Syndrome
- [ ] 12. Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma
- [ ] 13. Depression, Schizophrenia, or other forms of Psychosis or Mental Illness
- [ ] 14. Diabetes, Disease of the Pancreas or other glands
- [ ] 15. Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease
- [ ] 16. Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement
- [ ] 17. Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone
- [ ] 18. Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn’s Disease

- [ ] NONE OF THE ABOVE

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Section G: Medical History (Part 2)

Please give details below to all boxes checked in Question #1 of this section.

☑ 1. Drug or Alcohol Abuse

Dates of Condition	Physician's Name/Address/Phone	Description
From: 01/1985 To: ☐ Present Or 01/2006	☑ Same as Primary Care Doctor (Section F) name: James Smith address: 5689 First Street Suite 500 city/st/zip: Anytown ST 12345 phone: 810 - 256 - 8956	Prescription Drug Abuse

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Section G: Medical History (Part 3)

2. In the *past 3 years*, have you had any symptoms or knowledge of any other health condition that is not disclosed above? ◉ Yes ○ No
   Please describe:
   Acid Reflux

3. In the *past 3 years*, have you:
   a. taken any prescription medications? (if yes, please list) ◉ Yes ○ No

	Medication	Dosage	Reason	
✗	Nexium	50 mg	Acid Reflux	
✗				

Medication	Dosage	Reason
Nexium	50 mg	Acid Reflux

Add

   b. been confined in or advised to enter a hospital or rehabilitation facility? ◉ Yes ○ No

   Please explain and include dates and reasons:
   01/1986 Rehab Clinic for Prescription Drug abuse

   c. consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? If "Yes", please provide the Healthcare Professional's name, location, specialty, reason consulted and dates. ◉ Yes ○ No

	Name/Location/Specialty	Reason Consulted	Dates	
✗	Dave Jones/ Anytown, ST/ Gastro Interology	Acid Reflux	01/2000	
✗				

Dave Jones/ Anytown, ST/ Ga	Acid Reflux	01/2000

Add

   d. been advised by a healthcare professional to have a special evaluation testing or a surgery that has not been performed? ◉ Yes ○ No

   Please explain type, reason and scheduled date of the evaluation, testing or surgery:
   Endoscopy, Not Scheduled

   e. required assistance with shopping, using transportation, housekeeping, cooking or taking medications? ◉ Yes ○ No

   Please explain and include dates and reasons:
   Can't Drive

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Section H: Applicant Profile

1. Please provide your height 6 ft. 2 in., and weight 250 lbs.

2. In the *past 3 years*, have you used any form of tobacco or nicotine product? ◉ Yes ○ No

	Date Last Used	Types of Tobacco or Nicotine Products Used	
✖	05/18/2009	Cigarettes	✎
✖			✎

05/18/2009 | Cigarettes

Add

3. Do you work 20 or more hours a week outside your home? ◉ Yes ○ No

   Please list your occupation: Financial Analysist

4. Do you drive an automobile? ○ Yes ◉ No

   Please provide approximate annual mileage: _____ miles

5. With whom do you live?

   ○ alone ◉ spouse ○ family ○ other

6. Do you live in some form of a residential retirement community? ◉ Yes ○ No

   Please list the specific services that you are receiving (e.g., housekeeping, laundry, meals):

   Driving, Laundry

7. In the *past 3 years*, have you had any nursing home or long term care insurance application denied? ◉ Yes ○ No

   By which company?

   MetLife

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Section [F] [I]: Protection Against Unintended Lapse or Termination

I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand that notice will not be given to this person until 30 days after a premium is due and unpaid.

Please check one of the following:

- ☐ I elect NOT to designate another person to receive this Notice.
- ◉ I elect to designate another person to receive this Notice.

Complete the information below ONLY if you elect to name an authorized person.

Jane		Doe	
Name (First)	(MI)	(Last)	(Suffix)

1234 Main Street
Street Address

Apt. #

Anytown	ST	
City	**State**	**Zip Code**

810 - 235 - 6598
Phone Number

You may change the named designee at any time by notifying us in writing at the following address: LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

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Section [G] [J]: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? (•) Yes ( ) No

   Please provide the following details:

   Company Name: John Handcock

   Individual or Group Policy Number: 012562356

   Type of Coverage: Long Term Care

2. Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? (•) Yes ( ) No

   With which company? MetLife

   If that policy lapsed, when did it lapse? 01/2008

3. Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? (•) Yes ( ) No

   If "Yes", provide details:

   Company Name: MetLife

   Company Address: 1245 Granger, Anytow n, ST 12345

   -OR-

   Individual or Group Policy Number: 0152365

4. Are you currently covered by Medicaid? (not a reference to Medicare) (•) Yes ( ) No

Section [H] [K]: Other Notices to Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a Non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau
P.O. Box 105, Essex Station
Boston, Massachusetts 02111
866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116

info@YourLifeSecure.com

TELEPHONE INTERVIEW INFORMATION

To help process your Application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona**: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of **DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

To residents of **Kentucky**: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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To residents of **New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

To the residents of **Oklahoma**: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony.

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Section [I] [L]: Applicant Authorization and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- ☑ I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance.*
- ☑ I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Notice which appear in Section [H] [K] of this Application.
- ☑ I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- ☑ I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have No liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been No change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- ☑ I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
- ☐ I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- ☑ I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section [F] [I] of this Application.
- ☑ I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- ☑ I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

- ☑ I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance.

  That particular notice was delivered to me on: 05 / 02 / 2009

I certify that I have read, or have had read to me, the completed Application.

Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy.

I understand that I, or my authorized representative, may request to receive a copy of this authorization.

Clicking "Accept" represents my acknowledgement, acceptance and authorization of all statements checked above.

◉ **ACCEPT** ○ **DECLINE** Date: 05 / 18 / 2009

I certify that I have signed the Application in Anytown (**City**) ST (**State**)

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Section [J] [M]: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for Long Term Care Insurance from LifeSecure – specifically, for purposes of underwriting, servicing and claims (**in OK**: health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (**in AZ**, 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for Long Term Care Insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

Clicking "Accept" represents my acknowledgement and understanding of all statements above.

◉ **ACCEPT** ○ **DECLINE** Date: 05 / 18 / 2009

Since your application responses require LifeSecure to obtain an "Attending Physician Statement" to complete the application approval process, LifeSecure must obtain a paper copy of an "Applicant Authorization to Obtain and Disclose Information", signed by you. This signed paper copy will acknowledge your approval for LifeSecure to request and obtain and "Attending Physician Statement" from your physician. Please click the box below if you would like a paper copy of the authorization form sent to you via a mail delivery system for signature. Or, for quicker service, please download, print and sign the form from this link "HIPAA form". Fax the signed form to 1-888-550-5424 and then mail the form with your signature to: LifeSecure Administrative Offices, 3050 Universal Blvd., Ste. 150, Weston, FL 33331. Thank you.

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Coverage Summary

Premium Plan: **[Lifetime Payment Option]**
[10-Year Payment Option]
[To-Age-65 Option]

Benefit Bank Amount	[$75,000 - $1,000,0000]
Monthly Benefit Access Limit	[$XX,XXX] [(1%)] [(2%)] [(3%)]
Monthly Premium	[$XXX.XX]
Benefit Wait Period	[90] calendar days
Other Benefits Included	

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LifeSecure Insurance Company
10559 Citation Dr., Ste 300
Brighton, MI 48116

Section A: Personal Health History

1. Within the *past 12 months*, have you resided in or been advised by a healthcare professional to enter a Nursing Home, Assisted Living Facility or any other type of Long Term Care Facility? Or, within the *past 12 months*, have you used or been advised by a healthcare professional to use Home Health Care or Adult Day Care services? ☐ Yes ☑ No

2. Do you *currently* use any of the following: ☐ Yes ☑ No
   - Walker
   - Wheelchair
   - Quad Cane
   - Motorized scooter
   - Hospital bed
   - Oxygen equipment
   - Dialysis

3. Do you *currently* require human assistance in order to perform any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? ☐ Yes ☑ No

4. Do you have or have you ever been diagnosed or treated by a health care professional as having any of the following: ☐ Yes ☑ No
   - Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig's Disease)
   - Systemic Lupus Disease
   - Alzheimer's Disease
   - Dementia/Senility
   - Mental Retardation
   - Psychosis
   - Stroke (CVA) within past 5 years
   - Multiple Sclerosis (MS)
   - Muscular Dystrophy
   - Parkinson's Disease
   - Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test
   - Metastatic Cancer
   - Type I (Juvenile) Diabetes
   - Diabetes – treated/controlled with insulin for greater than 15 years or currently treated/controlled with greater than 49 units of insulin per day
   - A Transient Ischemic Attack (TIA) within past 2 years, *or* multiple TIAs within past 5 years
   - Chronic Kidney/Renal Disease
   - Huntington's Chorea
   - Cirrhosis of the Liver
   - Organ Transplant
   - Amputation due to Disease (not accident)

5. Are you *currently* receiving Social Security Disability benefits? ☐ Yes ☑ No

If you answered "**Yes**" to any part of any question in Section A, **PLEASE DO NOT CONTINUE.**
We regret that we cannot offer you long term care insurance coverage.
If your circumstances change, you may consider reapplying at a future time.

If you answered "**No**" to all questions in Section A, please **CONTINUE.**

Section B: Applicant Information

Employer/Group Name: ABC Company Group Number: 00001

Check ONLY one box below:

I, the applicant, am:

- ☑ an **employee** who regularly works [15] [20] [25] [30] or more hours per week for the employer named above. I am actively-at-work, which means I was working at my usual place of employment on the last regularly scheduled workday before I completed this application. My date of hire was: 01/01/2005 (month/year)
- ☐ a **spouse or domestic partner** of an eligible employee of the employer named above. His/her date of hire was: _____ (month/year)
- ☐ a **family member** of an eligible employee, or a **retiree/spouse,** or a **part-time employee/spouse** (who regularly works less than [15] [20] [25] [30] hours per week), of the employer named above.

☑ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

John _____ Doe _____
Name (First) (MI) (Last) (Suffix)

1234 Main Street _____
Street Address Apt #

Anytown ST 12345
City State Zip Code

01/01/1954
Date of Birth (mm/dd/yyyy)

123 - 56 - 7756 OR _____-_____
Social Security Number Tax Identification #

Gender:

☑ Male ☐ Female

Martial Status:

☐ Single ☑ Married ☐ Domestic Partner

810-659-2356 810-235-6593
Work Phone Number Home Phone Number

Best Time to Call: 9 a.m. 5 p.m.

Best Place to Call: ☑ Work ☐ Home

johnd@yahoo.com _____
E-mail Address Employee Number (if applicable)

1. Please select your **User Name** and **Password.** You'll use these to log onto the Policyholders Portal after your policy is approved. You'll also use your user name and password to log back onto the Groups & Associations Portal to complete your application, should you decide to save it and finish it later. The user name and password must be between 6 and 16 characters long and can contain only letters and numbers. Password must contain at least one number.

johnd	jand j	jand j
User Name	**Password**	**Confirm Password**

2. Next please enter a **Security Question** and the **correct answer** to the question. We will ask you this question if you forget your password. A correct answer will enable you to select a new password.

What was you first pet?
Security Question

Dog
Security Answer

Section C: Spouse Or Domestic Partner Information

PLEASE COMPLETE THE INFORMATION BELOW WHETHER OR NOT YOUR SPOUSE OR DOMESTIC PARTNER IS APPLYING. You may qualify for a couple's discount.

☐ Mr. ☑ Mrs. ☐ Ms. ☐ Dr.

Jane		Doe	
Name (First)	(MI)	(Last)	(Suffix)

125 - 95 - 1236
Social Security Number OR _____-_____
Tax Identification #

Is your spouse or domestic partner also applying for coverage? ☐ Yes ☑ No

Section D: Coverage Selections

BENEFIT BANK: Enter a dollar amount between $75,000 and $1,000,000 $75,000.

MONTHLY BENEFIT ACCESS LIMIT:

☑ 1% of Benefit Bank ☐ 2% of Benefit Bank ☐ 3% of Benefit Bank*

* 3% choice not available for Benefit Bank amounts greater than $500,000.

Your initial Monthly Benefit Access Limit dollar amount: $ 75,000 (Benefit Bank) x 1 % = $ 750 (Monthly Benefit)

MONEY-BACK PROMISE OPTION:

☑ Yes. I elect the Money-Back Promise Option as part of my coverage.

This optional benefit provides for a refund of a percentage of premiums (less benefits paid) to a beneficiary of your choice if you should die while holding your policy for 5 or more years.

Please enter the name of a primary and a contingent beneficiary who should receive such a refund, if any. Please note: If no beneficiary is named, any applicable refund (if any) will be made to your estate.

Primary Beneficiary ☑ Check here if this is your Spouse or Domestic Partner

☐ Mr. ☑ Mrs. ☐ Ms. ☐ Dr.

Jane (Name (First)) _____ (MI) Doe (Last) _____ (Suffix)

Wife
Relationship

1234 Main Street
Street Address

Apt #

Anytown
City

ST
State

12345
Zip Code

Contingent Beneficiary ☐ Check here if this is your Spouse or Domestic Partner

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name (First) (MI) (Last) (Suffix)

Relationship

Street Address

Apt #

City

State

Zip Code

☐ No. I reject the Money-Back Promise Option as part of my coverage.

OPTIONAL AUTOMATIC INFLATION PROTECTION: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. Specifically, I have reviewed options for 5% and 3% Automatic Compound Inflation Protection. My choice is as follows:

- ☐ I reject the Automatic Compound Inflation Protection options; however, I understand that my coverage will include the Guaranteed Future Purchase Offers feature.
- ☑ I elect Automatic 5% Compound Inflation Protection.
- ☐ I elect Automatic 3% Compound Inflation Protection.

OPTIONAL LAPSE PROTECTION BENEFIT:

- ☑ Yes. I elect to have the Lapse Protection Benefit as part of my coverage.
- ☐ No. I have reviewed the Outline of Coverage and compared the benefits and premiums of the policy with and without Lapse Protection benefits and I reject the Lapse Protection Benefit.

PREMIUM PAYMENT OPTIONS:

- ☑ Lifetime Payment Option
- ☐ 10-Year Premium Payment Option*
- ☐ To-Age-65 Premium Payment Option*

* These two limited-payment options are available only if you elected Automatic 5% Compound Inflation Protection or Automatic 3% Compound Inflation Protection as part of your coverage.

Total Monthly Premium[**]: **$** 750

[** If the employer stops contributing to your long term care insurance coverage for any reason in the future, the Total Monthly Premium represents the full amount of monthly premium that is required to keep your policy in force.]

Section E: Premium Payment Authorization

Complete this section to authorize your preferred premium payment method.

☐ **AUTOMATIC PAYROLL DEDUCTION** (applicable only for participating employers)

By electing this payment method, I authorize my employer to deduct my long term care insurance premiums automatically from my payroll.

Payroll System/Division: _____

Payroll Location: _____

Payroll Frequency: _____

Employee Number: _____

☑ **DIRECT-BILLING (MAIL)**

Select one billing frequency:

☐ annually ☑ semi-annually ☐ quarterly ☐ monthly ($2.00 monthly fee applicable)

OR

☐ **MONTHLY ELECTRONIC FUNDS TRANSFER**

How Monthly Electronic Funds Transfer Works: Monthly electronic funds transfer is a debit service that offers a convenient way to pay insurance premiums. LifeSecure Insurance Company will collect the long term care insurance premiums from your bank account electronically. You do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Monthly Electronic Funds Transfer Agreement:

I authorize LifeSecure to electronically withdraw money from my account for the payment of premiums for this insurance policy. I authorize LifeSecure to continue to make these withdrawals if there is a renewal, or other change in the policy. I will compensate LifeSecure for any loss, claim, or liability caused by these withdrawals and will not hold LifeSecure responsible for any such loss, claim, or liability. This authorization will not affect the terms of the policy. Authorizing this automatic payment plan does not put the insurance policy into effect. This authorization may be retracted by me or LifeSecure at any time for any reason by giving written notice. LifeSecure may retract the authorization immediately, without giving me written notice, if any debt is not paid by the bank stated below, for any reason.

Name of Bank: _____

Bank Address: _____

Telephone #: _____

Account Type: ☐ checking ☐ savings

Account #: _____

Routing #: _____

OR

☐ **AUTOMATIC CREDIT CARD PAYMENT**

Select Card Type: [☐ Visa] [☐ MasterCard] [☐ American Express] [☐ Discover Card]

Credit Card #: _____

Name as it appears on Card: _____

Expiration Date: _____

Section F: Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Care Doctor (i.e., the physician with most of your medical records).

James _____ _____ Smith _____ _____
Physician's Name (First) (MI) (Last) (Suffix)

5689 First Street _____ 500 _____
Street Address Suite #

Anytown _____ ST _____ 12345 _____
City State Zip Code

810-256-8956 _____
Office Phone Number

Have you seen this physician in the last two years? ☑ Yes ☐ No

Date of last visit: 01/2009 _____
month/year

Reason for visit:

Annual Physical _____

_____

_____

Section G: Medical History

1. In the *past 3 years*, have you received medical advice or treatment, been diagnosed by or consulted with a healthcare professional for any of the following conditions (check all that apply or NONE OF THE ABOVE).

- [x] 1. Drug or Alcohol Abuse
- [ ] 2. Disorders of Vision or Speech
- [ ] 3. Hypertension/High Blood Pressure, Chest Pain, Angina, Coronary Artery Disease
- [ ] 4. Heart Attack, Angioplasty or Heart Surgery
- [ ] 5. Transient Ischemic Attack (TIA), Carotid Artery Disease or Surgery
- [ ] 6. Congestive Heart Failure (CHF), Atrial Fibrillation, Pacemaker
- [ ] 7. Aneurysm, Peripheral Vascular Disease (PVD)
- [ ] 8. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Asthma, Chronic Bronchitis
- [ ] 9. Fainting Spells or Blacking Out, Seizures, Epilepsy
- [ ] 10. Tremor, Myasthenia Gravis
- [ ] 11. Paralysis (partial or full), Post Polio Syndrome
- [ ] 12. Cancer, Leukemia, Melanoma, Hodgkin's Disease or other Lymphoma, Multiple Myeloma
- [ ] 13. Depression, Schizophrenia, or other forms of Mental Illness
- [ ] 14. Diabetes, Disease of the Pancreas or other glands
- [ ] 15. Fibromyalgia, Chronic Fatigue, Lupus, Scleroderma, or other connective Tissue Disease
- [ ] 16. Injury due to Falls or Imbalance, Fractures, Amputation or Joint Replacement
- [ ] 17. Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Paget's Disease of the bone
- [ ] 18. Hepatitis C, Auto Immune Disorder, Ulcerative Colitis, Crohn's Disease

- [x] [ ] NONE OF THE ABOVE

Please give details below to all boxes checked in Question #1 of this section.
If you need more space, please attach an additional sheet of paper.

Number	Dates From/To	Physician's Name/Address/Phone	Describe
01	01/1985 to 01/2006	James Smith, Anytown, ST 12345 810-256-8956	Prescription Drug Abuse

2. In the *past 3 years*, have you had any symptoms or knowledge of any other health condition that is not disclosed above? ☑ Yes ☐ No

   If "Yes", please describe.

   Acid Reflux

3. In the *past 3 years,* have you:

   a. taken any prescription medications (if "Yes", please list)? ☑ Yes ☐ No

Medication	Dosage	Reason
Nexium	50 MG	Acid Reflux

   b. been confined in or advised to enter a hospital or rehabilitation facility? ☑ Yes ☐ No

   If "Yes", please explain and include dates and reasons.

   01/1986 Rehab Clinic for Prescription Drug Abuse

c. consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Care Doctor, podiatrist, dentist or allergist? ☑ Yes ☐ No

If "Yes", please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name/Location/Specialty	Reason(s)	Dates
Dave Jones, Anytown, ST, Gastro Interology	Acid Reflux	01/2000

d. been advised by a healthcare professional to have a special evaluation testing or a surgery that has not been performed? ☑ Yes ☐ No

If "Yes", please explain type, reason and scheduled date of the evaluation, testing or surgery.
Endoscopy, Not Scheduled

e. required assistance with shopping, using transportation, housekeeping, cooking or taking medications? ☑ Yes ☐ No

If "Yes", please explain and include dates and reasons.
Can't Drive

Section H: Applicant Profile

1. Please provide your height 6 ft 2 in (ft. & in.) and weight 250 (lbs.)

2. In the *past 3 years*, have you used any form of tobacco or nicotine product? ☑ Yes ☐ No

Date last used	List types of tobacco or nicotine products used
05/18/2009	Cigarette

3. Do you work 20 or more hours a week outside your home? ☑ Yes ☐ No
If "Yes", please list your occupation: Financial Analysist

4. Do you drive an automobile? ☐ Yes ☑ No
If "Yes", please provide approximate annual mileage: _____ miles

5. With whom do you live? ☐ alone ☑ spouse ☐ family ☐ other

6. Do you live in some form of a residential retirement community? ☑ Yes ☐ No
If "Yes", please list the specific services that you are receiving (e.g., housekeeping, laundry, meals).
Driving, Laundry

7. In the *past 3 years*, have you had any nursing home or long term care insurance application denied? ☑ Yes ☐ No
If "Yes", by which company?
MetLife

Section [F] [I]: Protection Against Unintended Lapse or Termination

I understand that I have the right to designate at least one authorized person, other than myself, to receive notice of lapse or termination of this long term care coverage due to nonpayment of premium. I understand that notice will not be given to this person until 30 days after a premium is due and unpaid.

Please check one of the following:

☐ I elect NOT to designate another person to receive this notice.

☑ I elect to designate another person to receive this notice.

Complete the information below ONLY if you elect to name an authorized person.

Jane _____ _____ Doe _____ _____
Name (First) (MI) (Last) (Suffix)

1234 Main Street _____
Street Address **Apt #**

Anytown _____ ST _____ 12345 _____
City **State** **Zip Code**

810-235-6598 _____
Phone Number

You may change the named designee at any time by notifying us in writing at the following address:
LifeSecure Administrative Office, P.O. Box 12834, Pensacola, FL 32591

Section [G] [J]: Replacement Inquiry

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage.

All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? ☑ Yes ☐ No

   If "Yes", provide details:

   Company Name: John Handcock

   Individual or Group Policy Number: 012562356

   Type of Coverage: Long Term Care

2. Did you have another long term care, nursing home, or home health care insurance policy or certificate in force during the past 12 months? ☑ Yes ☐ No

   If "Yes", provide details:

   Company Name: MetLife

   If that policy lapsed, when did it lapse? 01/2008

3. Did you intend to replace the above or any other long term care, medical or health insurance with this coverage? ☑ Yes ☐ No

   If "Yes", provide details:

   Company Name: MetLife

   Company Address: 1245 Granger, Anytown, ST 12345

   -OR-

   Individual or Group Policy Number: 0152365

4. Are you currently covered by Medicaid? (not a reference to Medicare) ☑ Yes ☐ No

Section [H] [K]: Other Notices To Applicant

MEDICAL INFORMATION BUREAU

LifeSecure or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address and phone number of the MIB's information office are:

Medical Information Bureau
P.O. Box 105, Essex Station
Boston, Massachusetts 02111
866.692.6901 (TTY 866.346.3642)

LifeSecure, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue insurance coverage, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may, in certain circumstances, be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or civil or criminal proceeding.

Upon your written request, LifeSecure will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information, and the role of insurance support organizations with regard to your information.

If you would like more information about our information practices, please write or e-mail us at:

LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116

info@YourLifeSecure.com

TELEPHONE INTERVIEW INFORMATION

To help process your Application as soon as possible, LifeSecure may have one of its representatives call you by telephone, at your convenience, in order to obtain additional underwriting information, or to clarify information related to your Application.

FRAUD WARNING:

For All States Not Listed Separately Below: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

To residents of **Arizona**: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an Application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the residents of **DC: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

To residents of **Kentucky:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an Application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

To residents of **Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

To residents of **New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

To the residents of **Oklahoma:** WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an Application containing false, incomplete, or misleading information is guilty of a felony.

Section [I] [L]: Applicant Authorizations and Signatures

Your signature, whether electronic or handwritten, represents your acknowledgement, acceptance and authorization of each statement checked below. The first four statements must be accepted before your Application can be processed. The remaining statements must be accepted before your Application can be processed *only* if you elected the optional choices referenced in those statements. Please read each statement carefully before providing your signature authorization.

- ☑ I acknowledge that I have received either printed or electronic copies of Things You Should Know Before Buying Long Term Care Insurance, Outline of Coverage, Personal Worksheet, Potential Rate Increase Disclosure Form, and *A Shopper's Guide to Long Term Care Insurance.*
- ☑ I acknowledge that I have read the Other Notices to Applicant regarding the Medical Information Bureau, Insurance Information Practices and Telephone Interview Information, and the Fraud Warning which appear in Section K of this Application.
- ☑ I acknowledge that I have reviewed my answers and statements to all sections of this Application. I declare that all information supplied here is true and complete to the best of my knowledge.
- ☑ I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure has the right to deny benefits or rescind my policy. I agree to notify LifeSecure of any change in my medical condition while my Application is pending. I understand that LifeSecure will have no liability until a policy is issued to me and the full first premium for the issued policy has been paid. I understand that the policy will not take effect until my Application is approved by LifeSecure and there has been no change in my health that would change the answer to any questions in my application.

CHECK ONLY THE FOLLOWING BOXES THAT APPLY TO OPTIONAL CHOICES MADE BY YOU IN OTHER SECTIONS OF THIS APPLICATION, AS SPECIFIED.

- ☑ I acknowledge my rejection of the Automatic Compound Inflation Protection options, as chosen in Section D of this Application.
- ☐ I acknowledge my rejection of the Lapse Protection Benefit option, as chosen in Section D of this Application.
- ☑ I acknowledge my decision to NOT designate another person to receive a notice of lapse or termination, as chosen in Section I of this Application.
- ☑ I acknowledge that LifeSecure is authorized to accept my premium payment withdrawals from my bank account or credit card, as chosen in Section E of this Application.
- ☑ I acknowledge that LifeSecure is authorized to accept my premium payments via automatic payroll deduction, as chosen in Section E of this Application.

CHECK THE BOX BELOW ONLY IF YOU SPECIFIED IN SECTION [G] [J] OF THIS APPLICATION THAT YOU PLAN TO REPLACE ANOTHER COVERAGE OR POLICY WITH THIS NEW COVERAGE.

☑ I acknowledge that I have read the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance. That particular notice was delivered to me on: _____.

I certify that I have read, or have had read to me, the completed Application.

Caution: I understand that if any of my answers on this Application are incorrect or untrue, LifeSecure may have the right to deny benefits or rescind my policy.

I understand that I, or my authorized representative, may request to receive a copy of this authorization.

Clicking "Accept" represents my acknowledgement, acceptance and authorization of all statements checked above.

☑ **ACCEPT** ☐ **DECLINE** **Date:** 05/18/2009

I certify that I have signed the Application in: Anytown, ST
City, State

Section [J] [M]: Applicant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:

I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, pharmacy or pharmacy benefit management (PBM) company, insurance company, consumer reporting agency, such as the Medical Information Bureau (MIB), or insurance support organization or other person or organization that has such information, to disclose the following categories of health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as HIV, AIDS or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to LifeSecure Insurance Company (LifeSecure) and any representatives performing services for LifeSecure, including its insurance support organizations, third-party administrators, affiliates, any reinsurers, and any consumer reporting agency such as the MIB.

Such disclosures may be made upon presentation of this form, or a copy of it. I recognize that such health information shall be used in connection with my Application for long term care insurance – specifically, for purposes of underwriting, servicing and claims (**in OK:** health information shall be used specifically for purposes of underwriting only).

I agree that this authorization will be valid for 24 months from the date signed (**in AZ,** 180 days). This authorization may be revoked upon submission of a written request to LifeSecure's administrative office: LifeSecure Administrative Office, 3050 Universal Blvd, Suite 150, Weston, FL 33331. Any action taken by LifeSecure (or one of its representatives) before receipt of the written notice of revocation will still be valid.

Although my signature on this form is voluntary, I understand that it is required to determine my insurability and qualification to be issued a long term care insurance policy from LifeSecure. Without my signature, I understand that my Application for long term care insurance cannot be processed. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws.

I understand that a copy of this signed authorization form will be provided to me or my authorized representative.

Clicking "Accept" represents my acknowledgement and understanding of all statements above.

☑ **ACCEPT** ☐ **DECLINE** **Date:** 05/18/2009

Since your application responses require LifeSecure to obtain an "Attending Physician Statement" to complete the application approval process, LifeSecure must obtain a paper copy of an "Applicant Authorization to Obtain and Disclose Information", signed by you. This signed paper copy will acknowledge your approval for LifeSecure to request and obtain and "Attending Physician Statement" from your physician. Please click the box below if you would like a paper copy of the authorization form sent to you via a mail delivery system for signature. Or, for quicker service, please download, print and sign the form from this link "HIPAA form". Fax the signed form to 1-888-550-5424 and then mail the form with your signature to: LifeSecure Administrative Offices, 3050 Universal Blvd., Ste. 150, Weston, FL 33331. Thank you.

LifeSecure Insurance Company
10559 Citation Drive, Suite 300
Brighton, MI 48116

SCHEDULE OF BENEFITS

Policyholder: [John Smith
10 Main Street
Anytown, USA 11111]

Policy Number: [LS-0000001]

Policy Effective Date: [05/01/07]

Age At Issue: [45]

[**Coverage Change Effective Date**: 07/01/10]

BENEFITS AND COVERAGE AMOUNTS

Benefit Bank:	[$75,000 - $1,000,000]
Monthly Benefit Access Limit:	[1%, 2% or 3% of Benefit Bank] [($###)]
[Guaranteed Future Purchase Offers:	Included]
[Contingent Non-Forfeiture Benefit:	Included]
Benefit Wait Period:	[30, 60, 90, 100, 120 or 180] Calendar Days

[OPTIONAL BENEFITS ELECTED]

[Money-Back Promise Option	Included]
[Automatic 3% Compound Inflation Protection Benefit:	Included]
[Automatic 5% Compound Inflation Protection Benefit:	Included]
[Lapse Protection Benefit:	Included]

PREMIUM INFORMATION

Premium Rate Classification:	[Preferred, Standard, Select, Multi-Life]
Premium Payment Mode:	[Monthly, Quarterly, Semi-annual, Annual]
Premium Payment Time Period:	[Lifetime, 10-years, To-age-65]

[Marital Discount Applied:	10%]
[Dual Spouse Coverage Discount Applied:	20%]
[Endorsed Association Discount Applied:	5%, 10%]
[Employer Contribution Discount:	5%]

Premium Amount[*]: **[$###] per [month, quarter, semi-annual period, year,]**
[$### per payroll deduction]

[*The premium amount includes the premium contribution, if any, paid by an employer sponsor.]

SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LFSC-126136721*	*State:*	*Arkansas*
Filing Company:	*LifeSecure Insurance Company*	*State Tracking Number:*	*42479*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Multi-Life Application Filing*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Flesch Certification 05/01/2009
Bypass Reason: Applications only
Comments:

Review Status:

Bypassed -Name: Application 05/01/2009
Bypass Reason: attached in the forms tabs
Comments:

Review Status:

Satisfied -Name: Health - Actuarial Justification 05/01/2009
Comments:
Attachment:
ACTMEM-Nationwide-MultiLife_Addendum_052009.pdf

Review Status:

Bypassed -Name: Outline of Coverage 05/01/2009
Bypass Reason: N/A - only filing applications, not replacing our currently approved Outline of Coverage
Comments:

Review Status:

Satisfied -Name: Explanation of Variability 05/26/2009
Comments:
Attachment:
Explanation of Variability.pdf

LifeSecure Insurance Company
Long Term Care Policy Form LS-0002
Addendum to Actuarial Memorandum

I. PURPOSE OF THIS FILING

The purpose of this actuarial addendum is to add the following rate classes to the original premiums filed:

1) A discounted set of rates for sales to individuals in employer groups, where the employee is paying his own premium. These rates are discounted 1% off the standard LS-0002 premiums.
2) A 5% additional discount will be applied to the rates from #1 for sales to individuals in employer groups, where the employer is contributing to the premium.
3) A discounted set of rates for sales to members of associations. These rates are discounted 5% off the rate class LS-0002 premiums.

II. GROUP DISCOUNT

At the discretion of the company, sales may be made to individuals in groups of policyholders that are list billed or marketed together, due to being part of an employer group, or to members of an association. For these multi-life sales, the attached discounted premiums will be used. Simplified underwriting may be used in the employer setting, based on group size and participation level. For association sales, agent compensation will be reduced.

III. ASSUMPTIONS

Relatively modest assumption changes were made, compared to base policy assumptions, as summarized below:

- Selection factors were increased for simplified underwriting (except for associations, which will use full underwriting),
- Commission rates were decreased for associations,
- Underwriting expenses were reduced for simplified underwriting,
- Voluntary lapse rates were increased for employer paid groups.

IV. CERTIFICATION

The certification of the original actuarial memorandum is not affected by the addition of these premium classes.

Dawn E. Helwig

Dawn E. Helwig, F.S.A., M.A.A.A.
Member, American Academy of Actuaries
May 20, 2009

LifeSecure Insurance Company
Annual Long Term Care Premiums - Policy Form LS-0002
90 Day Elimination Period; Daily Benefit = $100
Single Premiums; Sales to Individuals in Employer Groups*

Issue Age	Employee Pay Base Premiums** Monthly Payment, as % of Benefit Bank: 1% (8.3 year BP)	2% (4.2 year BP)	3% (2.8 year BP)
30 and under	$434	$393	$358
31	445	402	365
32	454	411	373
33	465	420	380
34	476	429	387
35	487	438	395
36	498	446	402
37	509	455	409
38	524	467	420
39	539	480	430
40	553	493	440
41	568	505	450
42	583	518	460
43	602	534	474
44	621	549	487
45	640	565	500
46	658	581	514
47	676	597	527
48	704	620	546
49	731	643	565
50	757	665	584
51	784	688	604
52	811	712	623
53	843	740	646
54	876	767	670
55	908	794	693
56	941	822	717
57	972	849	740
58	1,056	923	802
59	1,139	995	864
60	1,224	1,067	926
61	1,308	1,139	988
62	1,391	1,212	1,049
63	1,519	1,322	1,144
64	1,645	1,433	1,239
65	1,772	1,542	1,335
66	1,900	1,653	1,430
67	2,027	1,763	1,524
68	2,387	2,073	1,788
69	2,746	2,382	2,051
70	3,107	2,692	2,315
71	3,466	3,001	2,578
72	3,826	3,311	2,841
73	4,491	3,880	3,322
74	5,154	4,449	3,803
75	5,818	5,018	4,284
76	6,483	5,588	4,765
77	7,146	6,157	5,246
78	7,378	6,376	5,441
79	7,610	6,593	5,636
80	7,843	6,811	5,832
81	8,074	7,030	6,027
82	8,307	7,248	6,222
83	8,714	7,619	6,542
84	9,121	7,991	6,861

Adjustment Factors

Marital Discount: 30% if both purchase. (Multiply Single Rates by 0.70)
10% if only one purchases (Multiply Single Rates by 0.90)

** Employer Pay Factor: Apply 5% discount if employer contributes to premium.

* Applicability of multi-life rates are subject to certain group size and participation requirements.

LifeSecure Insurance Company
Annual Long Term Care Premiums- Policy Form LS-0002
90 Day Elimination Period; Daily Benefit = $100
Single, Standard Premiums; Sales to Individuals in Associations

Issue Age	Base Premiums Monthly Payment, as % of Benefit Bank: 1% (8.3 year BP)	2% (4.2 year BP)	3% (2.8 year BP)
30 and under	$416	$377	$344
31	427	386	351
32	436	394	358
33	447	403	365
34	457	411	371
35	467	420	379
36	478	428	386
37	488	437	392
38	503	448	403
39	517	461	412
40	531	473	422
41	545	485	432
42	560	497	442
43	578	512	455
44	596	527	467
45	614	542	480
46	632	558	493
47	649	573	505
48	675	595	524
49	701	617	542
50	727	638	561
51	752	660	580
52	778	683	598
53	809	710	620
54	841	736	643
55	871	762	665
56	903	789	688
57	933	815	710
58	1,014	885	770
59	1,093	955	829
60	1,174	1,024	888
61	1,255	1,093	948
62	1,335	1,163	1,007
63	1,457	1,268	1,098
64	1,579	1,375	1,189
65	1,701	1,480	1,281
66	1,823	1,587	1,372
67	1,945	1,692	1,462
68	2,290	1,989	1,716
69	2,635	2,286	1,968
70	2,981	2,583	2,221
71	3,326	2,879	2,474
72	3,672	3,177	2,727
73	4,309	3,723	3,188
74	4,946	4,269	3,649
75	5,583	4,816	4,111
76	6,221	5,362	4,572
77	6,857	5,908	5,034
78	7,080	6,118	5,221
79	7,303	6,327	5,408
80	7,526	6,536	5,596
81	7,748	6,746	5,784
82	7,971	6,955	5,971
83	8,362	7,311	6,278
84	8,752	7,668	6,584

***Adjustment Factors**

Marital Discount:	30% if both purchase. (Multiply Single Rates by 0.70) 10% if only one purchases (Multiply Single Rates by 0.90)
Preferred Rates:	Multiply Standard Rates by 0.90
Substandard Rates:	Multiply Standard Rates by 1.4

Explanation of Variability:

INDIVIDUAL LONG TERM CARE INSURANCE SCHEDULE OF BENEFITS (LS-0051 ST 08/09)

- The data fields for Policyholder, Policy Number, Policy Effective Date and Age At Issue are populated with sample data. Real applicant data will appear at issue.
- The Coverage Change Effective Date entry and its data field will appear only if there has been a coverage change at a future date from the Policy Effective Date.
- The data field for the Benefit Bank amount will be populated with the selected amount.
- The data field for the Monthly Benefit Access Limit will be populated with the selected percentage of Benefit Bank and the resulting dollar amount.
- Guaranteed Future Purchase Offers will appear with “Included” in its data field, only if it applies to the individual’s coverage. (It will apply as standard, unless the individual elected one of the two optional automatic inflation protection benefits.) If it does not apply, neither the benefit nor the data field will appear.
- Contingent Non-Forfeiture Benefit will appear with “Included” in its data field, only if it applies to the individual’s coverage. (It will apply as standard, unless the individual elected the optional Lapse Protection Benefit.) If it does not apply, neither the benefit nor the data field will appear.
- The data field for the Benefit Wait Period will be populated with the appropriate number of days.
- The Money-Back Promise Benefit will appear in the Optional Benefits Elected with “Included” in the data field, only if elected.
- Automatic 3% Compound Inflation Protection Benefit will appear, and “Included” will appear in its data field, only if it applies to the individual’s coverage. If it does not apply, neither the benefit nor the data field will appear.
- Automatic 5% Compound Inflation Protection Benefit will appear, and “Included” will appear in its data field, only if it applies to the individual’s coverage. If it does not apply, neither the benefit nor the data field will appear.
- Lapse Protection Benefit will appear, and “Included” will appear in its data field, only if it applies to the individual’s coverage. If it does not apply, neither the benefit nor the data field will appear.
- The applicable Premium Rate Classification will appear at issue in the data field.
- The applicable Premium Payment Mode will appear in that term’s data field.
- The applicable Premium Payment Time Period will appear in that term’s data field.
- The applicable Base Policy Coverage Modal Premium will appear in the term’s data field.
- The premium discount amount will appear in the data field for the Married Discount, Dual Spouse Coverage Discount and Endorsed Group Discount only if applicable to the individual’s coverage.
- The Employer Contribution Discount will only appear of the Premium Rate Classification is MultiLife and is applicable to the individual’s coverage.

- The modal premium amount for the Policyholder will appear in the data field for the Money-Back Promise Benefit (if optional), Automatic 3% Compound Inflation Protection Modal Premium, Automatic 5% Compound Inflation Protection Modal Premium, Lapse Protection Benefit Modal Premium. The entries and data fields will appear only if they apply to the individual's coverage.
- The asterisk next to the Premium Amount entry and the corresponding note below will appear only if the premium amount includes a premium contribution from a group sponsor.
- The actual dollar total for the Premium Amount and the applicable premium payment mode will appear at time of issue.
- The data field section of the Schedule of Benefits Print Date is illustrative and will be populated with a real date at issue.

Long Term Care Applications (LS-0204 ST 08/09 & LS-0205 ST 08/09)

Section B:

- The Minimum Hours (15, 20, 25, 30) will be chosen during design. They will be the only options that will be given.

Section D:

- The Benefit Bank Amount $400,000 is the maximum limit to receive Simplified Issue Qualification, the sponsor of the organization or employer will choose this amount during the plan setup. . The amount could be anywhere between $75,000 and $400,000. The issue ages for use of the Simplified Issue is 18 to 68. Persons 68 through 84 will complete the full application.

Section E:

- The credit card types are bracketed so that we may in the future offer Discover or American Express as payment options.

Sections F, G & H

- These sections are bracketed because if an applicant meets the Simplified Issue Qualifications these sections will not be completed and in the electronic versions will be suppressed and the applicant will not see the screens. If they do not meet the qualifications, these screens will appear and require the applicant to complete them.

- Section title (I),(J), (K), (L), (M), (N), (O) are bracketed so that if Sections F,G,H will not appear the section letters will follow in a correct alpha order.